

KANSAS ADMINISTRATIVE REGULATIONS

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KANSAS ADMINISTRATIVE REGULATIONS

AGENCY 21 KANSAS HUMAN RIGHTS COMMISSION

ARTICLE 30. GUIDELINES ON EMPLOYEE SELECTION PROCEDURES AND RECRUITMENT

21-30-2. "Test" defined. For the purpose of the guidelines in this part, the term "test" is defined as any paper-and-pencil or performance measure used as a basis for any employment decision. The guidelines in this part apply, for example, to ability tests which are designed to measure eligibility for hire, transfer, promotion, membership, training, referral or retention. This definition includes, but is not restricted to, measure of general intelligence, mental ability and learning ability; specific intellectual abilities; mechanical, clerical and other aptitudes; dexterity and coordination; knowledge and proficiency; occupational and other interests; and attitudes, personality or temperament. The term "test" includes all formal, scored, quantified or standardized techniques of assessing job suitability including, in addition to the above specific qualifying or disqualifying personal history or background requirements, specific educational or work history requirements, scored interviews, biographical information blanks, interviewers' rating scales, scored application forms, etc.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-3. "Discrimination" defined. The use of any test which adversely affects hiring, promotion, transfer or any other employment or membership opportunity of classes protected by the Kansas act against discrimination constitutes discrimination unless:

- (a) The test has been validated and evidences a high degree of utility as hereinafter described, and
- (b) the person giving or acting upon the results of the particular test can demonstrate that alternative suitable hiring, transfer or promotion procedures are unavailable for his use.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-5. Minimum standards for validation.

(a) For the purpose of satisfying the requirements of this part, empirical evidence in support of a test's validity must be based on studies employing generally accepted procedures for determining criterion-related validity, such as those described in "standards for educational and psychological tests and manuals" published by American Psychological Association, 1200 17th Street N. W., Washington, D. C. 20036. Evidence of content or construct validity, as defined in that publication, may also be appropriate where criterion-related validity is not feasible. However, evidence for content or construct validity should be accompanied by sufficient information from job analyses to demonstrate the relevance of the content (in the case of job knowledge or proficiency tests) or the construct (in the case of trait measures). Evidence of content validity alone may be acceptable for well-developed tests that consist of suitable samples of the essential knowledge, skills or behaviors composing the job in question. The types of knowledge, skills, or behaviors contemplated here do not include those which can be acquired in a brief orientation to the job.

(b) Although any appropriate validation strategy may be used to develop such empirical evidence, the following minimum standards, as applicable, must be met in the research approach and in the presentation of results which constitute evidence of validity:

- (1) Where a validity study is conducted in which tests are administered to applicants, with criterion data collected later, the sample of subjects must be representative of the normal or typical candidate group for the job or jobs in question. This further assumes that the applicant sample is representative of the minority population available for the job or jobs in question in the local labor market. Where a validity study is

conducted in which tests are administered to present employees, the sample must be representative of the minority groups currently included in the applicant population. If it is not technically feasible to include minority employees in validation studies conducted on the present work force, the conduct of a validation study without minority candidates does not relieve any person of his subsequent obligation for validation when inclusion of minority candidates becomes technically feasible.

(2) Tests must be administered and scored under controlled and standardized conditions, with proper safeguards to protect the security of test scores and to insure that scores do not enter into any judgments of employee adequacy that are to be used as criterion measures. Copies of tests and test manuals, including instructions for administration, scoring, and interpretation of tests results, that are privately developed and/or are not available through normal commercial channels, must be included as a part of the validation evidence.

(3) The work behaviors or other criteria of employee adequacy which the test is intended to predict or identify must be fully described; and, additionally, in the case of rating techniques, the appraisal form(s) and instructions to the rater(s) must be included as a part of the validation evidence. Such criteria may include measures other than actual work proficiency, such as training time, supervisory ratings, regularity of attendance and tenure. Whatever criteria are used they must represent major or critical work behaviors as revealed by careful job analyses.

(4) In view of the possibility of bias inherent in subjective evaluations, supervisory rating techniques should be carefully developed, and the ratings should be closely examined for evidence of bias. In addition, minorities might obtain unfairly low performance criterion scores for reasons other than supervisors' prejudice, as, when, as new employees, they have had less opportunity to learn job skills. The general point is that all criteria need to be examined to insure freedom from factors which would unfairly depress the scores of minority groups.

(5) Differential validity. Data must be generated and results separately reported for minority and nonminority groups whenever technically feasible. Where a minority group is sufficiently large to constitute an identifiable factor in the local labor market, but validation data have not been developed and presented separately for that group, evidence of satisfactory validity based on other groups will be regarded as only provisional compliance with these guidelines pending separate validation of the test for the minority group in question. (See 21-30-9.) A test which is differentially valid may be used in groups for which it is valid but not for those in which it is not valid. In this regard, where a test is valid for two groups but one group characteristically obtains higher test scores than the other without a corresponding difference in job performance, cutoff scores must be set so as to predict the same probability of job success in both groups.

(c) In assessing the utility of a test the following considerations will be applicable:

(1) The relationship between the test and at least one relevant criterion must be statistically significant. This ordinarily means that the relationship should be sufficiently high as to have a probability of no more than 1 to 20 to have occurred by chance. However, the use of a single test as the sole selection device will be scrutinized closely when that test is valid against only one component of job performance.

(2) In addition to statistical significance, the relationship between the test and criterion should have practical significance. The magnitude of the relationship needed for practical significance or usefulness is affected by several factors, including: (a) The larger the proportion of applicants who are hired for or placed on the job, the higher the relationship needs to be in order to be practically useful. Conversely, a relatively low relationship may prove useful when proportionately few job vacancies are available. (b) The larger the proportion of applicants who become satisfactory employees when not selected on the basis of the test, the higher the relationship needs to be between the test and a criterion of job success for the test to be practically useful. Conversely, a relatively low relationship may prove useful when proportionately few applicants turn out to be satisfactory. (c) The smaller the economic and human risks involved in hiring an unqualified applicant relative to the risks entailed in rejecting a qualified applicant, the greater the relationship needs to be in order to be practically useful. Conversely, a relatively low relationship may prove useful when the former risks are relatively high.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-6. Presentation of validity evidence. The presentation of the results of a validation study must include graphical and statistical representations of the relationships between the test and the criteria, permitting judgments of the test's utility in making predictions of future work behavior. [See 21-30-5 (c) concerning assessing utility of a test.] Average scores for all tests and criteria must be reported for all relevant subgroups, including minority and nonminority groups where differential validation is required. Whenever statistical adjustments are made in validity results for less than perfect reliability or for restriction of score range in the test or the criterion, or both, the supporting evidence from the validation study must be presented in detail. Furthermore, for each test that is to be established or continued as an operational employee selection instrument, as a result of the validation study, the minimum acceptable cutoff (passing) score on the test must be reported. It is expected that each operational cutoff score will be reasonable and consistent with normal expectations of proficiency within the work force or group on which the study was conducted.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-7. Use of other validity studies. In cases where the validity of a test cannot be determined pursuant to 21-30-4 and 21-30-5 (e.g., the number of subjects is less than that required for a technically adequate validation study, or an appropriate criterion measure cannot be developed), evidence from validity studies conducted in other organizations, such as that reported in test manuals and professional literature, may be considered acceptable when:

- (a) The studies pertain to jobs which are comparable (i.e., have basically the same task elements), and
- (b) There are no major differences in contextual variables or sample composition which are likely to significantly affect validity.

Any person citing evidence from other validity studies as evidence of test validity for his own jobs must substantiate in detail job comparability and must demonstrate the absence of contextual or sample differences cited in paragraphs (a) and (b) of this section.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-8. Assumption of validity.

(a) Under no circumstances will the general reputation of a test, its author or its publisher, or casual reports of test utility be accepted in lieu of evidence of validity. Specifically ruled out are: assumptions of validity based on test names or descriptive labels; all forms of promotional literature; data bearing on the frequency of a test's usage; testimonial statements of sellers, users, or consultants; and other nonempirical or anecdotal accounts of testing practices or testing outcomes.

(b) Although professional supervision of testing activities may help greatly to insure technically sound and nondiscriminatory test usage, such involvement alone shall not be regarded as constituting satisfactory evidence of test validity.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-9. Continued use of tests. Under certain conditions, a person may be permitted to continue the use of a test which is not at the moment fully supported by the required evidence of validity. If, for example, determination of criterion-related validity in a specific setting is practicable and required but not yet obtained, the use of the test may continue: Provided:

- (a) The person can cite substantial evidence of validity as described in 21-30-7 (a) and (b); and
- (b) He has in progress validation procedures which are designed to produce, within a reasonable time, the additional data required. It is expected also that the person may have to alter or suspend test cutoff scores so that score ranges broad enough to permit the identification of criterion-related validity will be obtained.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-10. Employment agencies and employment services.

(a) An employment service, including private employment agencies, and state employment agencies, as defined in K.S.A. 44-1002 (e), shall not make applicant or employee appraisals or referrals based on the results obtained from any psychological test or other selection standard not validated in accordance with these guidelines.

(b) An employment agency or service which is requested by an employer or union to devise a testing program is required to follow the standards for test validation as set forth in these guidelines. An employment service is not relieved of its obligation herein because the test user did not request such validation or has requested the use of some lesser standard than is provided in these guidelines.

(c) Where an employment agency or service is requested only to administer a testing program which has been elsewhere devised, the employment agency or service shall request evidence of validation, as described in the guidelines in this part, before it administers the testing program and/or makes referral pursuant to the test results. The employment agency must furnish on request such evidence of validation. An employment agency or service will be expected to refuse to administer a test where the employer or union does not supply satisfactory evidence of validation. Reliance by the user on the reputation of the test, its author, or the name of the test shall not be deemed sufficient evidence of validity [see 21-30-8 (a)]. An employment agency or service may administer a testing program where the evidence of validity comports with the standards provided in 21-30-7.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-11. Disparate treatment. The principle of disparate or unequal treatment must be distinguished from the concepts of test validation. A test or other employee selection standard--even though validated against job performance in accordance with the guidelines in this part--cannot be imposed upon any individual or class protected by the Kansas act against discrimination where other employees, applicants or members have not been subjected to that standard. Disparate treatment, for example, occurs where members of a minority group have been denied the same employment, promotion, transfer or membership opportunities as have been made available to other employees or applicants. Those employees or applicants who have been denied equal treatment, because of prior discriminatory practices or policies, must at least be afforded the same opportunities as had existed for other employees or applicants during the period of discrimination. Thus, no new test or other employee selection standard can be imposed upon a class of individuals protected by the Kansas act against discrimination who, but for prior discrimination, would have been granted the opportunity to qualify under less stringent selection standards previously in force.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-12. Retesting. Employers, unions, and employment agencies should provide an opportunity for retesting and reconsideration to earlier "failure" candidates who have availed themselves of more training or experience. In particular, if any applicant or employee during the course of an interview or other employment procedure claims more education or experience, that individual should be retested.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-13. Other selection techniques. Selection techniques other than tests, as defined in 21-30-2, may be improperly used so as to have the effect of discriminating against minority groups. Such techniques include, but are not restricted to, unscored or casual interviews and unscored application forms. Where there are data suggesting employment discrimination, the person may be called upon to present evidence concerning the validity of his unscored procedures as well as of any tests which may be used, the evidence of validity being of the same types referred to in 21-30-4 and 21-30-5. Data suggesting the possibility of discrimination exist, for example, when there are differential rates of applicant rejection from various minority and nonminority groups for the same job or group of jobs or when there are disproportionate representations of minority and nonminority groups among present employees in different types of jobs. If the person is unable or unwilling to perform such validation studies, he has the option of adjusting employment procedures so as to eliminate the conditions suggestive of employment discrimination.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-14. Affirmative action. Nothing in these guidelines shall be interpreted as diminishing a person's obligation under the Kansas act against discrimination to undertake affirmative action to ensure that applicants or employees are treated without regards to race, religion, color, national origin or ancestry. Specifically, the use of tests which have been validated pursuant to these guidelines does not relieve employers, unions or employment agencies of their obligations to take positive action in affording employment and training to members of classes protected by the Kansas act against discrimination.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-15. Word-of-mouth recruiting. Employers and/or labor organizations whose workforces or memberships do not bear a reasonable relationship to the racial and/or ethnic pattern of the general population in their recruiting areas, may not recruit exclusively or even primarily by means of word-of-mouth referrals from present employees or present members.

Authorized by K.S.A. 1971 Supp. 44-1004, 44-1005; effective Jan. 1, 1972.

21-30-16. Preference to relatives, friends or neighbors of present employees or members. Employers and/or labor organizations whose workforces or memberships do not bear a reasonable relationship to the racial and/or ethnic pattern of the general population in their recruiting areas, may not give preference in hiring or in admission to membership to relatives, friends or neighbors of present employees or present members by reason of such relationships.

Authorized by K.S.A. 1974 Supp. 44-1004, 44-1005; effective Jan. 1, 1972; amended, E-74-14, Dec. 28, 1973; amended May 1, 1975.

21-30-17. Pre-employment inquiries and practices. K.S.A. 44-1009 (a) (3) prohibits, among others, the following pre-employment or pre-membership inquiries and practices:

- (a) Inquiry into the birthplace of an applicant, the applicant's spouse or parents or any other close relative.
- (b) Any requirement that an applicant submit a birth certificate, naturalization or baptismal record with his application.
- (c) Any requirement or suggestion that an applicant submit a photograph with his application or at any time before he is hired.
- (d) Inquiry into the name and address of any relative of an adult applicant other than applicant's spouse or children.

- (e) Any inquiry into organization memberships, the name or character of which could indicate the race, religion, color, national origin or ancestry of the applicant.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-30-18. Affirmative action file.

(a) Affirmative action file, need and use. Where affirmative action to increase the opportunity of minority groups for employment appears necessary to eliminate the effects of past pattern or individual discriminatory practices on the part of certain respondents and to assure future compliance with the Kansas act against discrimination, the commission may require and order per K.A.R. 21-45-21 an employer to maintain and utilize the application of potentially qualified minority group members in an "affirmative action file" when the commission has determined that such affirmative action is necessary to effectuate the purposes of the law. Before consulting other sources for applicants the commission may require that the respondent will give every consideration to the hiring of applicants from this file.

(b) Minority. "Minority" as used here means any person against whom an employer has been or is discriminating based on race, color, religion, sex, national origin or ancestry.

(c) Provisions. The affirmative action file provision in any conciliation agreement or commission order may provide, but is not limited to, the following provisions:

"Affirmative action file:

"1. Applications of members of minority groups which are not accepted or rejected per subpart (c) (4) hereof, shall be placed in a file, to be known as an affirmative action file. This file shall consist of all minority group applicants who are qualified for any position with the respondent, and those applicants whose qualifications have not been established.

"2. As job vacancies occur, the respondent shall consult the affirmative action file to determine if qualified applicants are available from the minority group members listed therein.

"3. Before consulting other sources for applicants, the respondent will give every consideration to the hiring of applicants from this file.

"4. If, after further review at the time a vacancy is available, the respondent concludes that the applicant is not qualified and cannot become qualified for any job within respondent's employ, he should remove his name from the file and notify him and the appropriate organization and agencies as identified in the commission order or conciliation agreement. If the applicant is still considered qualified, the respondent shall note on the file the date of each review and the reason for rejection. If the respondent is of the view that certain steps taken by the applicant could qualify him for employment, it shall so inform the applicant and the referring and sending institution, in writing, maintaining a copy in his file.

"5. The operation of the file shall be reported as provided by the commission."

Authorized by K.S.A. 1974 Supp. 44-1003, 1004; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-30-19. Recruitment and referral agencies.

(a) Public and private services. Where necessary to eliminate the continuing effects of prior discrimination, the commission may require employers "to establish continuing relationships with referral sources which may include, but is not limited to,

- (1) Public referral services and agencies; and
- (2) Private referral agencies and services, including those operated for profit."

(b) Recruitment. To the extent where necessary to eliminate the continuing effects or prior discrimination the commission may require employers to advertise vacancies and non-discriminatory hiring practices.

Authorized by K.S.A. 1974 Supp. 44-1003, 44-1004; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-30-20. Temporary employment. Where necessary to eliminate the continuing effects of prior discrimination, the commission may require employers to hire its summer, seasonal or any other temporary employees on the same basis as permanent employees.

Authorized by K.S.A. 1974 Supp. 44-1003, 44-1004; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

**AGENCY 21 KANSAS HUMAN RIGHTS COMMISSION
ARTICLE 31. GUIDELINES ON DISCRIMINATION BECAUSE OF NATIONAL ORIGIN
OR ANCESTRY**

21-31-1. Construction of BFOQ Exemption. The bona fide occupational qualification exemption of K.S.A. 44-1009 (a) (3) shall be strictly construed as it pertains to cases of national origin or ancestry.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-31-2. Covert and overt discrimination. The Kansas act against discrimination is intended to eliminate covert as well as the overt practices of discrimination, and the commission will, therefore, examine with particular concern cases where persons within the jurisdiction of the commission have been denied equal opportunities for reasons which are grounded in national origin or ancestry considerations. Examples of cases of this character include: The use of tests in the English language where the individual tested came from circumstances where English was not that person's first language or mother tongue, and where English language skill is not a requirement of the task to be performed; denial of equal opportunity to persons married to or associated with persons of a specific national origin or ancestry; denial of equal opportunity because of membership in lawful organizations identified with or seeking to promote the interests of national groups; denial of equal opportunity because of attendance at schools or churches commonly utilized by persons of a given national origin or ancestry; denial of equal opportunity because their name or that of their spouse reflects a certain national origin or ancestry; and denial of equal opportunity to persons who as a class of persons tend to fall outside national norms for height and weight where such height and weight specifications are not necessary for the performance of the work involved.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-31-3. Protection of noncitizens. The Kansas act against discrimination protects all individuals, both citizens and noncitizens, domiciled, residing or transient in the state of Kansas, against discrimination in employment, public accommodations and housing because of race, religion, color, national origin or ancestry.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

21-31-4. Protection of national security. Because discrimination on the basis of citizenship has the effect of discriminating on the basis of national origin, a lawfully immigrated alien who is domiciled, residing or transient in the state of Kansas may not be discriminated against on the basis of his citizenship, except that it is not an unlawful practice for an employer to refuse to employ any person who does not fulfill the requirements imposed in the interest

of federal or state security pursuant to any statute of the United States or the state of Kansas or pursuant to any executive order of the president or the governor respecting the particular position or the particular premises in question.

Authorized by K.S.A. 1971 Supp. 44-1004; effective Jan. 1, 1972.

**AGENCY 21 KANSAS HUMAN RIGHTS COMMISSION
ARTICLE 32. GUIDELINES ON DISCRIMINATION BECAUSE OF SEX**

21-32-1. Sex as a bona fide occupational qualification.

(a) The bona fide occupational qualification exceptions as to sex should be interpreted narrowly. Labels--"men's jobs" and "women's jobs"--tend to deny employment opportunities unnecessarily to one sex or the other.

(1) The commission will find that the following situations do not warrant the application of the bona fide occupational qualification exceptions:

(a) The refusal to hire a woman because of her sex, based on assumptions of the comparative employment characteristics of women in general. For example, the assumption that the turnover rate among women is higher than among men.

(2) The refusal to hire an individual based on stereotyped characterizations of the sexes. Such stereotypes include, for example, that men are less capable of assembling intricate equipment; that women are less capable of aggressive salesmanship. The principle of nondiscrimination requires that individuals be considered on the basis of individual capacities and not on the basis of any characteristics generally attributed to the group.

(3) The refusal to hire an individual because of the preference of co-workers, the employer, clients or customers.

(4) The fact that the employer may have to provide separate facilities for a person of the opposite sex will not justify discrimination under the bona fide occupational qualification unless the expense would be clearly unreasonable.

(b) The employer must not make any distinction based upon sex in employment opportunities, wages, hours, or other conditions of employment.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; regulation modified by 1975 HB 2633, May 6, 1975.

21-32-2. Fringe benefits. "Fringe benefits," as used herein includes medical, hospital, accident, life insurance and retirement benefits; profit sharing and bonus plans; leave and other terms, conditions and privileges of employment.

(a) It shall be an unlawful employment practice for an employer to discriminate between men and women with regard to fringe benefits.

(b) Where an employer conditions benefits available to employees and their spouses and families on whether the employee is the "head of the household" or "principle wage earner" in the family unit, the benefits tend to be available only to male employees and their families. Due to the fact that such conditioning discriminatorily affects the rights of women employees, and that "head of the household" or "principle wage earner" status bears no relationship to job performance, benefits which are so conditioned will be found a prima facie violation of the prohibitions against sex discrimination contained in the act.

(c) It shall be an unlawful employment practice for an employer to make available benefits for the wives and families of male employees where the same benefits are not made available for the husbands and families of female employees; or to make available benefits for the wives of male employees which are not made available for female employees; or to make available benefits to the husbands of female employees which are not made available for male employees. An example of such an unlawful employment practice is the situation in which wives of male employees receive maternity benefits while female employees receive no such benefits.

(d) It shall not be a defense to a charge of sex discrimination in benefits that the cost of such benefits is greater with respect to one sex than the other.

(e) It shall be an unlawful employment practice for an employer to have a pension or retirement plan which establishes different optional or compulsory retirement ages on the basis of sex, or which differentiates in benefits on the basis of sex.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-3. Separate lines of progression and seniority systems.

(a) It is an unlawful employment practice to classify a job as "male" or "female" or to maintain separate lines of progression or separate seniority lists based on sex where this would adversely affect any employee unless sex is a bona fide occupational qualification for that job. Accordingly, employment practices are unlawful which arbitrarily classify jobs so that:

- (1) A female is prohibited from applying for a job labeled "male" or for a job in a "male" line of progression; and vice versa.
- (2) A male scheduled for layoff is prohibited from displacing a less senior female on a "female" seniority list; and vice versa.

(b) A seniority system or line of progression which distinguishes between "light" and "heavy" jobs constitutes an unlawful employment practice if it operates as a disguised form of classification by sex, or creates unreasonable obstacles to the advancement by members of either sex into jobs which members of that sex could reasonably be expected to perform.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-4. Discrimination against married women.

(a) The commission has determined that an employer's rule which forbids or restricts the employment of married women and which is not applicable to married men is a discrimination based on sex prohibited by the Kansas act against discrimination. It does not seem to us relevant that the rule is not directed against all females, but only against married females, for so long as sex is a factor in the application of the rule, such application involves a discrimination based on sex. This rule also applies to unmarried women who happen to be mothers for example; in many instances women who have small children in the home are denied employment. Such discrimination usually takes place at the initial employer's screening process through the asking of such questions as "How old are your children? How many children do you have? What are your plans for providing care for your children?"

(b) An employed woman should not have her employment terminated when she marries a man who works for the same business or institution by whom she is employed. At the same time, a woman should not be denied employment by an employer due to rules against nepotism if she is otherwise qualified to perform the required work.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-5. Pre-employment inquiries as to sex. Pre-employment inquiry may ask "Male. . . , Female . . . ;" provided that the inquiry is made in good faith for a non-discriminatory purpose. Any pre-employment inquiry in connection with prospective employment which expresses directly or indirectly any limitation, specification or discrimination as to sex shall be unlawful unless based upon a bona fide occupational qualification.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-6. Pregnancy and childbirth.

(a) A written or unwritten employment policy or practice which excludes from employment applicants or employees because of pregnancy is prima facie discrimination.

(b) Disabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth and recovery therefrom, are for all job related purposes, temporary disabilities and should be treated as such under any health or temporary disability insurance or sick leave plan available in connection with employment. Written or unwritten employment policies and practices involving matters such as the commencement and duration of leave, the availability of extensions, the accrual of seniority and other benefits and privileges, reinstatement, and payment under any health or temporary disability insurance or sick leave plan, formal or informal, shall be applied to disability due to pregnancy or childbirth on the same terms and conditions as they are applied to other temporary disabilities.

(c) Where the termination of an employee who is temporarily disabled is caused by an employment policy under which insufficient or no leave is available, such termination is discriminatory if it has a disparate impact on employees of one sex and is not justified by business necessity.

(d) Childbearing must be considered by the employer to be a justification for a leave of absence for female employees for a reasonable period of time. Following childbearing, and upon signifying her intent to return within a reasonable time, such female employee shall be reinstated to her original job or to a position of like status and pay without loss of service, credits, seniority or other benefits.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-7. Affirmative action. The employer shall take affirmative action to recruit women to apply for those jobs where they have been previously excluded. Such affirmative action may include but is not limited to notifying employment referral agencies that women are welcome to apply for all positions, recruiting at women's colleges and the use of advertising which is not classified by sex.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

21-32-8. Job opportunities advertising. It is a violation of the Kansas act against discrimination for a help wanted advertisement to indicate a preference, limitation, specification or discrimination based on sex unless sex is a bona fide occupational qualification for the particular job involved. The placement of an advertisement in columns classified by publishers on the basis of sex, such columns headed "male" or "female," will be considered as an expression of preference, limitation, specification or discrimination based on sex.

Authorized by K.S.A. 1974 Supp. 44-1004(3), 44-1009; effective, E-73-5, Nov. 16, 1972; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

AGENCY 21 KANSAS HUMAN RIGHTS COMMISSION
ARTICLE 33. GUIDELINES ON DISCRIMINATION BECAUSE OF RELIGION

21-33-1. Statement of purpose.

(a) The guidelines in this part have been adopted to contribute to the implementation of non-discriminatory personnel policies with respect to employee religious beliefs as required by the Kansas act against discrimination. The guidelines in this part are designed to serve as a workable set of standards for employers, unions and employment agencies in determining whether their policies concerning employee religious beliefs conform with the basic purposes of the elimination of discrimination in employment as defined by the act.

(b) Observance of sabbath and other religious holidays. Regarding whether it is discrimination on account of religion to discharge or refuse to hire employees who regularly observe Friday evening and Saturday, or some other day of the week, as the Sabbath or who observe certain special religious holidays during the year and, as a consequence, do not work on such days, the commission finds that the duty not to discriminate on religious grounds, under the act, includes an obligation on the part of the employer to make reasonable accommodations to the religious needs of employees and prospective employees where such accommodations can be made without undue hardship on the conduct of the employer's business. Such undue hardship, for example, may exist where the employee's needed work cannot be performed by another employee of substantially similar qualifications during the period of absence of the Sabbath observer. Because of the particularly sensitive nature of discharging or refusing to hire an employee or applicant on account of his religious beliefs, the employer has the burden of proving that an undue hardship renders the required accommodations to the religious needs of the employee unreasonable. The commission will review each case in an effort to seek an equitable application of these guidelines to the variety of situations which arise due to the varied religious practices of the people of Kansas.

Authorized by K.S.A. 1974 Supp. 44-1004, 44-1005; effective, E-74-14, Dec. 28, 1973; effective May 1, 1975.

AGENCY 21 KANSAS HUMAN RIGHTS COMMISSION
ARTICLE 34. GUIDELINES ON DISCRIMINATION BECAUSE OF DISABILITY

21-34-1. Definitions.

(a) "Covered entity" means an employer, labor organization, employment agency, or joint labor-management committee.

(b) "Direct threat" means a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation.

(c) "Essential function" means the fundamental job duties of the employment position the individual with a disability holds or desires. The term "essential function" does not include the marginal functions of the position.

(d) "Has a record of such impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(e) "Is regarded as having such an impairment" means:

(1) Has a physical or mental impairment that does not substantially limit major life activities but is treated by a covered entity as constituting a limitation;

(2) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward the impairment; or

(3) Has none of the impairments defined in subsections (h)(1) or (2) of this section but is treated by a covered entity as having an impairment.

(f) "Illegal use of drugs" means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act (21 U.S.C. 812). This term does not include the use of a drug taken under the supervision of a licensed health care professional, or other uses authorized by Controlled Substances Act or other provisions of Federal or Kansas law.

(g) "Major life activities" means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(h) "Physical or mental impairment" means:

(1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or

(2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(i) "Qualified individual with a disability" means an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position the person holds or desires, and who, with or without reasonable accommodation, can perform the essential functions of the position.

(j) "Qualification standards" means the personal and professional attributes including the skill, experience, education, physical, medical, safety and other requirements established by a covered entity as requirements which an individual must meet in order to be eligible for the position held or desired.

(k) "Substantially limits" means:

(1) unable to perform a major life activity that the average person in the general population can perform; or

(2) significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform the same major life activity.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-2. Medical examinations and inquiries; general prohibition. The prohibition against discrimination as referred to in K.S.A. 44-1009(a)(1) and 44-1009(a)(8) shall include medical examinations and inquiries.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-3. Preemployment medical examinations and inquiries.

(a) Prohibited examination or inquiry. A covered entity shall not conduct a medical examination or make inquiries of a job applicant as to whether the applicant is an individual with a disability or as to the nature or severity of the applicant's disability, except as provided in 21-34-4.

(b) Acceptable inquiry. A covered entity may make preemployment inquiries into the ability of an applicant to perform job-related functions.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-4. Employment entrance examinations and inquiries; exception. A covered entity may require a medical examination, inquiry, or both after an offer of employment has been made to a job applicant and prior to the commencement of the employment duties of the applicant, and may condition an offer of employment on the results of the examination, inquiry, or both if:

- (a) all entering employees in the same job category are subjected to an examination, inquiry, or both regardless of disability;
- (b) information obtained regarding the medical condition or history of the applicant is collected and maintained on separate forms and in separate medical files and is treated as a confidential medical record, except that:
 - (1) supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and necessary accommodations;
 - (2) first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment; and
 - (3) government officials investigating compliance with this act shall be provided relevant information on request; and
- (c) the results of such physical examination, inquiry, or both are used only in accordance with these regulations.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-5. Prohibited medical examinations and inquiries. A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-6. Acceptable medical examinations and inquiries.

- (a) A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at the work site. A covered entity may make inquiries into the ability of an employee to perform job-related functions.
- (b) Information obtained under subsection (a) regarding the medical condition or history of any employee is subject to the requirements of subsections (b) and (c) of 21-34-4.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-7. Regulation of alcohol and drugs. These regulations do not prohibit a covered entity from:

- (a) prohibiting the illegal use of drugs and the use of alcohol at the workplace by all employees;
- (b) requiring that employees not be under the influence of alcohol or drugs at the workplace;

(c) requiring that employees behave in conformance with the requirements established pursuant to the Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.);

(d) holding an employee who engages in the illegal use of drugs or who is an alcoholic to the same qualification standards for employment or job performance and behavior that the entity holds other employees, even if any unsatisfactory performance or behavior is related to the employee's drug use or alcoholism;

(e) requiring that its employees employed in an industry subject to federal regulations comply with the standards established in those regulations, if any, regarding alcohol and the illegal use of drugs; and

(f) requiring that employees employed in sensitive positions in an industry subject to federal regulations comply with those regulations, if any, that apply to employment in sensitive positions.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-8. Drug testing.

(a) A test to determine the illegal use of drugs shall not be considered a medical examination.

(b) Nothing in this paragraph shall be construed to encourage, prohibit, or authorize the conducting of drug tests for the illegal use of drugs by job applicants or employees or making employment decisions based on the test results.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-9. Transportation employees. Nothing in these regulations should be construed to encourage, prohibit, restrict or authorize the otherwise lawful exercise by entities subject to the jurisdiction of the United States Department of Transportation of authority to:

(a) test employees of entities in, and applicants for, positions involving safety sensitive duties for the illegal use of drugs and/or for on-duty impairment by alcohol; and

(b) remove persons who test positive for illegal use of drugs or on-duty impairment by alcohol pursuant to subsection (b)(1) of this regulation from safety-sensitive positions.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-10. Information from a drug test. Any information regarding the medical condition or history of any employee or applicant obtained from a drug test, except information regarding illegal use of drugs, is subject to the requirements of subsections (b) and (c) of 21-34-4.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-11. Illegal use of drugs and alcohol; exception to the definition of "qualified individuals with a disability"; policies and procedures.

(a) The term "qualified individual with a disability" shall not include any employee or applicant who is engaging in the illegal use of drugs, when the covered entity acts on the basis of the illegal use of drugs.

(b) Nothing in subsection (a) of this regulation shall be construed to exclude as a "qualified individual with a disability" an individual who:

(1) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in the illegal use of drugs; or

(2) is participating in a supervised rehabilitation program and is no longer engaging in the illegal use of drugs; or

(3) is erroneously regarded as engaging in the illegal use of drugs, but is not engaging in the illegal use of drugs.

(c) It shall not be a violation of this act for a covered entity to adopt or administer reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual described in paragraph (b)(1) or (2) of this section is no longer engaging in the illegal use of drugs.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-12. Regulation of smoking. A covered entity may prohibit or impose restrictions on smoking in places of employment.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-13. Direct threat; criteria for determination.

(a) The determination that an individual with a disability poses a "direct threat" shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge, on the best available objective evidence, or both.

(b) In determining whether an individual would pose a direct threat, the factors to be considered include:

(1) the duration of the risk;

(2) the nature and severity of the potential harm;

(3) the likelihood that the potential harm will occur; and

(4) the imminence of the potential harm.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-14. Essential function; criteria for determination.

(a) A job function may be considered essential for any of several reasons, including but not limited to the following:

(1) the function may be essential because the reason the position exists is to perform that function;

(2) the function may be essential because of the limited number of employees available among whom the performance of that job function can be distributed; and

(3) the function may be highly specialized so that the incumbent in the position is hired for his or her expertise or ability to perform the particular function.

(b) Evidence of whether a particular function is essential includes, but is not limited to:

(1) the employer's judgment as to which functions are essential;

(2) written job descriptions prepared before advertising or interviewing applicants for the job;

(3) the amount of time spent on the job performing the function;

(4) the consequences of not requiring the incumbent to perform the function;

(5) the terms of a collective bargaining agreement;

(6) the work experience of past incumbents in the job; and

(7) the current work experience of incumbents in similar jobs.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-15. Direct threat as qualification standard. The term "qualification standards" may include a requirement that an individual shall not pose a direct threat to the health or safety of that individual or others in the workplace.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-16. Infectious and communicable diseases; food handling jobs.

(a) If an individual with a disability is disabled by an infectious or communicable disease and if the risk of transmitting the disease associated with the handling of food cannot be eliminated by reasonable accommodation, a covered entity may refuse to assign or continue to assign the individual to a job involving food handling. However, if the individual with a disability is a current employee, the employer must consider whether he or she can be accommodated by reassignment to a vacant position not involving food handling.

(b) This regulation does not preempt, modify, or amend any State, county, or local law, ordinance or regulation applicable to food handling which:

(1) provide greater or equal protection for the rights of individuals with disabilities disabled by an infectious or communicable disease that are afforded by the Americans with Disabilities Act of 1990; and

(2) is designed to protect the public from individuals who pose a significant health risk to the health and safety of others, where that risk cannot be eliminated by reasonable accommodation.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-17. Substantially limit; criteria for determination.

(a) The following factors should be considered in determining whether an individual is substantially limited in a major life activity:

- (1) the nature and severity of the impairment;
- (2) the duration or expected duration of the impairment; and
- (3) the permanent or long term impact of the impairment, or the expected permanent or long term impact of the impairment.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-18. Substantially limit; definition with respect to the major life activity of "working"; criteria for determination.

(a) With respect to the major life activity of "working," the term "substantially limits" means significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working.

(b) In addition to the factors listed in paragraph (a) of 21-34-17, the following factors may be considered in determining whether an individual is substantially limited in the major life activity of "working":

- (1) the geographical area to which the individual has reasonable access;
- (2) the job from which the individual has been disqualified because of an impairment, and the number and types of jobs utilizing similar training, knowledge, skills or abilities, within that geographical area, from which the individual is also disqualified because of the impairment (class of jobs); and
- (3) the job from which the individual has been disqualified because of an impairment, and the number and types of other jobs not utilizing similar training, knowledge, skill or abilities, within that geographical area, from which the individual is also disqualified because of the impairment (broad range of jobs in various classes).

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-19. Undue hardship; definition; criteria for determination.

(a) "Undue hardship" means an action requiring significant difficulty or expense.

(b) Criteria for determination. In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include:

- (1) the nature and net cost of the accommodation needed under this act, taking into consideration the availability of tax credits and deductions, outside funding, or both;
- (2) (A) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation;
- (B) the number of persons employed at the facility;

- (C) the effect on expenses and resources, or any other impact of the accommodation upon the operation, of the facility;
- (3) (A) the overall financial resources of the covered entity;
 - (B) the overall size of the business of a covered entity with respect to the number of its employees;
 - (C) the number, type, and location of its facilities; and
- (4) (A) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of the entity;
 - (B) the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-20. Exceptions to the definitions of "disability."

- (a) The term "disability" does not include:
 - (1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;
 - (2) compulsive gambling, kleptomania, or pyromania; or
 - (3) psychoactive substance use disorders resulting from current illegal use of drugs.
- (b) Homosexuality and bisexuality are not impairments and so are not disabilities as defined in this act.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

21-34-21. Health insurance, life insurance, and other benefit plans.

- (a) An insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers benefit plans, or similar organizations, may underwrite risks, classify risks, or administer risks that are based on or not inconsistent with State law.
- (b) A covered entity may establish, sponsor, observe or administer the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law.
- (c) A covered entity may establish, sponsor, observe, or administer the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.
- (d) The activities described in paragraphs (a), (b), and (c) are permitted unless these activities are a subterfuge to evade the purposes of this act.

Authorized by K.S.A. 44-1004; implementing K.S.A. 44-1009, as amended by L. 1991, Chapter 147, Section 6; effective, T-21-3-27-92, March 27, 1992; effective April 27, 1992.

**AGENCY 22 STATE FIRE MARSHAL
ARTICLE 5. FIRE REPORTING REQUIREMENTS**

22-5-6. Reporting of burn wounds. Hospitals which treat burn patients and doctors or other health care providers who treat burn patients at any location other than a hospital shall report all second-and third-degree burn wounds involving 20% or more of the victim's body and requiring hospitalization of the victim to the state fire marshal on forms provided by the state fire marshal. Each report shall be mailed no later than the Monday following the date of the first treatment of any wound.

Authorized by and implementing L. 1988, Ch. 127, Sec. 1(7); effective May 1, 1986; amended Aug. 28, 1989.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 1. DISEASES**

28-1-1. Definitions.

(a) "Carrier" means an infected person (or animal) that harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source of infection for humans.

(b) "Chemoprophylaxis" means the administration of a chemical, including antibiotics, to prevent the development of an infection or the progression of an infection to active manifest disease.

(c) "Infectious or contagious (communicable) disease" means a disease of humans or animals resulting from an infection or an illness due to a specific agent or its toxic products which arises through transmission of that agent or its products from a reservoir to a susceptible host, either directly, or indirectly.

(d) "Communicable period" means the time or times during which an infectious agent may be transferred directly or indirectly from an infected person to another person, from an infected animal to a person, or from an infected person to an animal, including arthropods.

(e) "Contact" means a person or animal that has been in association with an infected person or animal or a contaminated environment so as to have had opportunity to acquire the infection.

(f) "Contamination" means the presence of an infectious agent on a body surface, or on or in clothes, bedding, toys, surgical instruments or dressings, or other inanimate articles or substances including water, milk, and food.

(g) "Disinfection" means killing of infectious agents outside the body by chemical or physical means. Concurrent disinfection is the application of disinfective measures as soon as possible after the discharge of infectious material from the body of an infected person, or after the soiling of articles with this infectious discharge, all personal contact with these discharges or articles being minimized before that disinfection. Terminal disinfection is the application of disinfective measures after an infected person or animal has ceased to be a source of infection, has been removed from a specific site, or has died and been removed.

(h) "Disease" means a definite morbid process having a characteristic train of symptoms.

(i) "Epidemic (or outbreak)" means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy and derived from a common or propagated source.

(j) "Incubation period" means the time interval between exposure to an infectious agent and appearance of the first sign or symptom of the disease in question.

(k) "Infection" means the entry and development or multiplication of an infectious agent in the body of humans or animals. Infection is not synonymous with infectious disease; the result may be inapparent or manifest.

(l) "Infectious agent" means an organism, chiefly a microorganism but including helminths, that is capable of producing infection or infectious disease.

(m) "Infestation" means, for persons or animals, the lodgement, development and reproduction of arthropods on the surface of the body or in clothing.

(n) "Isolation" means the separation, for the period of communicability, of infected persons or animals from others, in places and under conditions that prevent the direct or indirect conveyance of the infectious agents from those infected to those who are susceptible or who may spread the agent to others.

(1) When "Respiratory isolation" is specified, it shall consist of a private room with door kept closed, handwashing upon entering and leaving the room, and disinfection of articles contaminated with patient secretions. Persons susceptible to the specific disease must wear masks.

(2) "Enteric precautions" shall consist of hand-washing upon entering and leaving the patient room, wearing of gloves by all persons having direct contact with the patient or with articles contaminated with fecal material, and wearing of gowns by all persons having direct contact with the patient. Articles contaminated with the patient's urine or feces shall be disinfected or discarded; masks are not necessary.

(3) "Blood precautions" shall consist of use of disposable needles and syringes, disposal of used needles and syringes by incineration, and decontamination and sterilization of all non-disposable equipment which is contaminated by blood.

(o) "Local health officer" means the person appointed as local health officer by the board of county commissioners in accordance with K.S.A. 65-201.

(p) "Nosocomial infection" means an infection originating in a medical facility. This includes infections acquired in the hospital but appearing after discharge; it also includes infections among staff.

(q) "Quarantine" means the limitation of freedom of movement of well persons or domestic animals that have been exposed to a communicable disease.

Authorized by and implementing K.S.A. 1981 Supp. 65-101; effective May 1, 1982.

28-1-2. Designation of infectious or contagious diseases.

(a) The following diseases shall be designated as infectious or contagious in their nature, and cases or suspect cases shall be reported within seven days, unless otherwise specified, in accordance with K.S.A. 65-118 and K.S.A. 65-128, and amendments thereto.

- (1) Amebiasis;
- (2) Anthrax (report by telephone within four hours to the secretary);
- (3) Botulism (report by telephone within four hours to the secretary);
- (4) Brucellosis;
- (5) Campylobacter infections;
- (6) Chancroid;
- (7) Chlamydia trachomatis genital infection;
- (8) Cholera (report by telephone within four hours to the secretary);

- (9) Cryptosporidiosis;
- (10) Cyclospora infection;
- (11) Diphtheria;
- (12) Encephalitis or meningitis, arboviral (indicate infectious agent whenever possible);
- (13) Ehrlichiosis;
- (14) Escherichia coli enteric infection from E. coli O157:H7 and other enterohemorrhagic, enteropathogenic, and enteroinvasive E. coli;
- (15) Giardiasis;
- (16) Gonorrhea;
- (17) Haemophilus influenzae, invasive disease;
- (18) Hemolytic uremic syndrome, postdiarrheal;
- (19) Hepatitis B in pregnancy (report the pregnancy of each woman with hepatitis B);
- (20) Hepatitis, viral;
- (21) Hantavirus pulmonary syndrome;
- (22) Legionellosis;
- (23) Leprosy or Hansen's disease;
- (24) Listeriosis;
- (25) Lyme disease;
- (26) Malaria;
- (27) Measles or rubeola (report by telephone within four hours to the secretary);
- (28) Meningitis, bacterial (indicate causative agent, if known, and report by telephone within four hours to the secretary);
- (29) Meningococemia (report by telephone within four hours to the secretary);
- (30) Mumps (report by telephone within four hours to the secretary);
- (31) Pertussis or whooping cough (report by telephone within four hours to the secretary);
- (32) Plague (report by telephone within four hours to the secretary);
- (33) Poliomyelitis (report by telephone within four hours to the secretary);
- (34) Psittacosis;
- (35) Rabies, animal and human (report by telephone within four hours to the secretary);

- (36) Rocky Mountain spotted fever;
- (37) Rubella, including congenital rubella syndrome (report by telephone within four hours to the secretary);
- (38) Salmonellosis, including typhoid fever;
- (39) Severe acute respiratory syndrome (SARS) (report by telephone within four hours to the secretary);
- (40) Shigellosis;
- (41) Streptococcal invasive disease from group A Streptococcus or Streptococcus pneumoniae;
- (42) Syphilis, including congenital syphilis;
- (43) Tetanus;
- (44) Toxic-shock syndrome, streptococcal and staphylococcal;
- (45) Trichinosis;
- (46) Tuberculosis, active and latent (report active disease by telephone within four hours to the secretary);
- (47) Tularemia;
- (48) Varicella or chickenpox;
- (49) Yellow fever; and
- (50) Any exotic or newly recognized disease, and any disease unusual in incidence or behavior, known or suspected to be infectious or contagious and constituting a risk to the public health (report by telephone within four hours to the secretary).

(b) The occurrence of a single case of any unusual disease or manifestation of illness that the health care provider determines or suspects could be caused by or related to a bioterrorism act. The term "bioterrorism act," as used in this article, shall mean a dispersion of biological or chemical agents with the intention to harm. Each bioterrorism act shall be reported within four hours by telephone to the secretary. The following shall be considered bioterrorism agents when identified in the course of a possible bioterrorism act:

- (1) Anthrax;
- (2) Plague;
- (3) Smallpox;
- (4) Tularemia;
- (5) Botulism;
- (6) Viral hemorrhagic fever;
- (7) Q fever;
- (8) Brucellosis; and
- (9) Any other infectious or toxic agent that can be intentionally dispersed in the environment.

Authorized by K.S.A. 65-101 and 65-128; implementing K.S.A. 65-128 and 65-202; effective May 1, 1982; amended May 1, 1986; amended Dec. 24, 1990; amended April 19, 1993; amended Jan. 12, 1996; amended Dec. 1, 1997; amended Feb. 18, 2000; amended, T-28-11-20-03, Nov. 20, 2003; amended March 5, 2004.

28-1-4. Registration of disease prevalence.

(a) The administrator of each hospital licensed in the state shall report the following diseases to the secretary:

- (1) All diseases listed in K.A.R. 28-1-2;
- (2) Cancer, as required by K.A.R. 28-70-2;
- (3) Congenital malformations in infants under one year of age;
- (4) Acquired immune deficiency syndrome; and
- (5) Fetal alcohol syndrome.

(b) The administrator of each hospital licensed in the state shall report the following information to the secretary when requested by the secretary and for the duration specified by the secretary, if this information is in the hospital's possession:

- (1) The number of laboratory test orders and the results for specified infectious or contagious diseases;
- (2) The number of pharmacy prescriptions for medications used to treat specified infectious or contagious diseases;
- (3) The number of emergency room visits for symptoms related to specified infectious or contagious diseases; and
- (4) Utilization rates of other services that can provide an early warning of a disease outbreak, if that information can be provided by the hospital with minimum additional burden.

(c) The administrator of each hospital licensed in the state may designate a person within the hospital to report diseases on behalf of the individuals required by K.S.A. 65-118, and amendments thereto, to report these diseases for cases that these individuals observe while practicing at the hospital. Each report from the designated hospital person shall fulfill all reporting requirements for individuals required by K.S.A. 65-118, and amendments thereto, to report these cases.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-102; effective May 1, 1982; amended May 1, 1986; amended Jan. 12, 1996; amended Oct. 16, 1998; amended, T-28-11-20-03, Nov. 20, 2003; amended March 5, 2004.

28-1-5. General provisions for isolation or quarantine of persons afflicted with infectious or contagious disease; examination of persons; collection of specimens.

(a) When conditions of isolation and quarantine are not otherwise specified by regulation, the local health officer or the secretary of health and environment shall order and enforce isolation and quarantine of persons afflicted with or exposed to infectious or contagious diseases. The duration and manner of isolation or quarantine so ordered shall be based upon the incubation period, communicable period, and usual mode of transmission of the infectious agent of the disease for which isolation or quarantine is ordered.

(b) Isolation or quarantine shall be ordered in conjunction with investigation of infectious or contagious disease cases and outbreaks for the examination of persons reasonably suspected of having these diseases, and to obtain specimens from these persons for laboratory evidence suggestive of infectious or contagious disease.

Authorized by K.S.A. 65-128, K.S.A. 1981 Supp. 65-101; implementing K.S.A. 1981 Supp. 65-101; effective May 1, 1982.

28-1-6. Requirements for isolation and quarantine of specific infectious and contagious diseases. The following isolation precautions, as defined in K.A.R. 28-1-1, shall be observed:

- (a) Amebiasis: Infected food handlers shall be excluded from their occupation until three negative stools have been obtained. Both the second and the third specimens shall be collected at least 48 hours after the prior specimen.
- (b) Anthrax: Infected persons shall be isolated until all lesions are healed.
- (c) Chickenpox: Infected persons shall be isolated for six days after the first crop of vesicles appears or until lesions are crusted, whichever comes first.
- (d) Cholera: Enteric precautions shall be followed for the duration of acute symptoms. Contacts shall be quarantined for five days from the date of last exposure.
- (e) Diphtheria: Infected persons shall be isolated for 14 days or until two consecutive negative pairs of nose and throat cultures, and cultures of skin lesions in cutaneous diphtheria, are obtained at least 24 hours apart and not less than 24 hours after discontinuation of antibiotic therapy. Household and intimate contacts shall be quarantined for seven days from the time of last contact or until nose and throat cultures are negative. Healthy carriers shall be treated.
- (f) E. coli O157:H7: Enteric precautions shall be followed for the duration of acute symptoms. Infected persons shall be excluded from food handling, patient care, or occupations involving the care of young children and the elderly, and infected children shall not attend a day care center until two negative stool cultures are obtained at least 24 hours apart and no sooner than 48 hours following discontinuation of antibiotics.
- (g) Gonorrhea ophthalmia neonatorum: Infected persons shall be isolated for 48 hours following initiation of treatment with antibiotics or until two negative cultures are obtained.
- (h) Malaria: Blood precautions shall be followed for the duration of hospitalization.
- (i) Meningitis, meningococcal: Respiratory isolation shall be instituted for 24 hours after initiation of antibiotic therapy.
- (j) Meningitis, aseptic and other: Infected persons shall be isolated until the end of the febrile period.
- (k) Mumps: Respiratory isolation shall be instituted for nine days from the onset of parotid gland swelling.
- (l) Pediculosis: Students infested with lice shall be excluded from school or child care facilities until treatment with an antiparasitic drug is initiated, and until all nits have been removed.
- (m) Pertussis (whooping cough): Respiratory isolation shall be instituted for three weeks if untreated, or for five days following initiation of antibiotic therapy.
- (n) Plague (pneumonic): Airborne precautions shall be instituted until completion of 48 hours of antibiotic therapy and there has been a favorable clinical response. Close contacts who do not receive chemoprophylaxis shall be quarantined for seven days.

- (o) Poliomyelitis: Infected persons shall be isolated for 10 days from onset; enteric precautions shall be followed for six weeks.
- (p) Rubeola (measles): Respiratory isolation shall be instituted for four days after the onset of rash.
- (q) Rubella (German measles): Respiratory isolation shall be followed for seven days after the onset of rash.
- (r) Salmonellosis (nontyphoidal): Enteric precautions shall be followed for the duration of acute symptoms. Infected persons with diarrhea shall be excluded from food handling, patient care, or occupations involving the care of young children and the elderly until no longer symptomatic. Asymptomatic and convalescent infected persons without diarrhea may be excluded from, and return to, this work by the order of the local health officer or the department.
- (s) Scabies: Children or students infected with scabies shall be excluded from school or child care facilities until treated with an antiparasitic drug.
- (t) Shigellosis: Enteric precautions shall be followed for duration of acute symptoms. Infected persons shall be excluded from food handling, patient care, or occupations involving the care of young children and the elderly until two negative stool cultures are obtained at least 24 hours apart and no sooner than 48 hours following the discontinuation of antibiotics.
- (u) Staphylococcal disease: Infected food handlers shall be excluded from their occupation until purulent lesions are healed.
- (v) Streptococcal disease, hemolytic (including erysipelas, scarlet fever, streptococcal sore throat): Infected persons shall be isolated for 10 days if untreated or for 24 hours following initiation of antibiotic therapy.
- (w) Taeniasis (beef or pork tapeworm): Enteric precautions shall be followed until treated.
- (x) Tinea capitis and corporis (ringworm): Infected children or students shall be excluded from school until under treatment by a physician.
- (y) Tuberculosis: Respiratory isolation shall be instituted until three sputa obtained on consecutive days are negative by microscopic examination.
- (z) Typhoid fever: Enteric precautions shall be followed for the duration of acute symptoms. Infected persons shall be restricted from food handling, patient care, or occupations involving the care of young children and the elderly until three negative stool cultures, and urine cultures in patients with schistosomiasis, have been obtained. Both the second and the third specimens shall be collected at least 24 hours after the prior specimen. The first specimen shall be collected no sooner than 48 hours following the discontinuation of antibiotics, and not earlier than one month after onset. If any one of these tests is positive, cultures shall be repeated monthly until three consecutive negative cultures are obtained.
- (aa) Sexually transmitted diseases (including syphilis, gonorrhea, chlamydia, and other diseases associated with sexual transmission): Isolation or quarantine measures shall be established by the local health officer for persons who are confirmed or suspected of being infected with a sexually transmitted disease if these persons are recalcitrant to proper treatment.
- (bb) Viral hepatitis type A (infectious): Blood and enteric precautions shall be followed for two weeks after the onset of symptoms. Infected persons shall be restricted from food handling, patient care, or occupations involving the care of young children and the elderly until two weeks after the onset of illness.

Authorized by K.S.A. 65-128, K.S.A. 65-101; implementing K.S.A. 65-101; effective May 1, 1982; amended May 1, 1986; amended Sept. 5, 1997; amended July 16, 1999.

28-1-7. Isolation of food handlers with infectious or contagious diseases. Persons employed in the preparation of food for sale or for public consumption shall be excluded from their occupations until all requirements for release from isolation of the specific infectious or contagious disease with which they are afflicted, as specified in K.A.R. 28-1-6, have been met.

Authorized by K.S.A. 1981 Supp. 65-101, K.S.A. 65-128; implementing K.S.A. 1981 Supp. 65-101; effective May 1, 1982.

28-1-12. Release from isolation or quarantine. All laboratory tests or cultures for release of an individual from isolation or quarantine shall be performed by the laboratory of the state department of health and environment, or by a laboratory approved by the state department of health and environment for this purpose.

Authorized by K.S.A. 65-128, K.S.A. 1981 Supp. 65-101; implementing K.S.A. 1981 Supp. 65-101; effective May 1, 1982.

28-1-18. Notification of Kansas department of health and environment by laboratories of positive reaction to tests for certain diseases.

(a) To assist in the control of disease in Kansas, each person who is in charge of a clinical laboratory shall notify the Kansas department of health and environment within 48 hours after testing, unless otherwise specified in this regulation, any specimen derived from the human body that yields microscopical, cultural, immunological, serological, or other evidence suggestive of those diseases that are significant from a public health standpoint.

(b) (1) Each notification shall include the following:

(A) The date and result of the test performed;

(B) the name of the person from whom the specimen was obtained;

(C) when available, either the date of birth or the age, and the address and telephone number of the person from whom the specimen was obtained; and

(D) when available, the name and address of the physician for whom the examination or test was performed, and any other information required by the secretary.

(2) A legible copy of the laboratory report delivered by confidential electronic transmission or mail, or a confidential telephone communication of the laboratory report shall satisfy the notification requirement of this subsection.

(c) The conditions or diseases to which this regulation applies shall include the following:

(1) All diseases listed in K.A.R. 28-1-2;

(2) All blood lead level test results as follows:

(A) Blood lead level test results greater than or equal to 10 micrograms per deciliter for persons less than 18 years of age, and greater than or equal to 25 micrograms per deciliter for persons 18 years of age or older shall be reported within 48 hours; and

(B) blood lead level test results less than 10 micrograms per deciliter for persons less than 18 years of age, and less than 25 micrograms per deciliter for persons 18 years of age or older shall be reported within 30 days; and

(3) CD4+ T-lymphocyte count of less than 500 per microliter or a CD4+ T-lymphocyte percent of total lymphocytes less than 29.

(d) Isolates of positive cultures of the following microorganisms shall be sent to the Kansas department of health and environment, division of health and environmental laboratories, unless this requirement is waived under special circumstances by the secretary of health and environment:

(1) Salmonella;

(2) Shigella;

(3) Escherichia coli O157:H7 and other enterohemorrhagic, enteropathogenic, and enteroinvasive E. coli;

(4) Neisseria meningitidis;

(5) Streptococcal invasive disease from group A Streptococcus or Streptococcus pneumoniae; and

(6) Mycobacterium tuberculosis.

(e) All laboratory notifications required in this regulation shall be confidential and shall not be open to public inspection, as provided in K.S.A. 65-118 and amendments thereto.

Authorized by and implementing K.S.A. 65-101, K.S.A. 2001 Supp. 65-118, and K.S.A. 65-128; effective, E-68-22, Aug. 9, 1968; effective Jan. 1, 1969; amended May 1, 1986; amended Aug. 23, 1993; amended Jan. 12, 1996; amended Dec. 1, 1997; amended Feb. 18, 2000; amended, T-28-8-9-02, Aug. 9, 2002; amended Dec. 2, 2002.

28-1-26. Protection of confidentiality of information regarding individuals with HIV infection.

(a) Definitions. The following definitions shall have the meaning specified below:

(1) "AIDS" means the acquired immune deficiency syndrome.

(2) "Authorized personnel" means individuals who have signed a confidentiality statement.

(3) "Confidentiality statement" means a written statement, dated and signed by an applicable individual, that certifies the individual's agreement to abide by the security policy of a public health agency and this regulation.

(4) "Counseling and testing site" means a site where counseling and testing for HIV infection is available.

(5) "HIV" means the human immunodeficiency virus.

(6) "HIV confidential information" means all combinations of individual data elements or information collected for surveillance purposes under the requirements of K.S.A. 65-6002 and amendments thereto, in electronic or hard copy, that could identify anyone with HIV or AIDS, including the name, date of birth, address, and other identifying information.

(7) "HIV confidentiality officer" means the official in the public health agency responsible for implementing and enforcing all the measures to protect HIV confidential information as defined under this regulation.

- (8) "HIV infection" means the presence of HIV in the body.
- (9) "HIV report" means a report of HIV infection or AIDS transmitted to a public health agency under the requirements of K.S.A. 65-6002 and amendments thereto.
- (10) "Public health agency" means any organization operated by any state or local government that acquires, uses, discloses, or stores HIV confidential information for public health purposes.
- (11) "Secretary" means the secretary of health and environment.
- (12) "Secured area" means the physical confinement limiting where HIV confidential information is available.
- (13) "Written security policy" means written specifications of the measures adopted to protect HIV confidential information and a description of how to implement these measures.
- (b) Each public health agency shall appoint an HIV confidentiality officer, who shall have the authority to make decisions about the agency operations that may affect the protection of HIV confidential information.
- (c) HIV confidential information shall be maintained in a secured area that is not easily accessible through a window and that is protected by a locked door. Access to the secured area shall be limited to authorized personnel only, and "Restricted area--No unauthorized access" signs shall be prominently posted. Access to the secured area by cleaning crews and other building maintenance personnel shall be granted only during hours when authorized personnel are available for escort or under conditions in which the data is protected by security measures specified in the written security policy.
- (d) Hard copy records containing HIV confidential information shall be kept in a locked cabinet located in a secured area, except when in use by authorized personnel. Records shall not be removed from a secured area without authorization from the HIV confidentiality officer.
- (e) Electronic records containing HIV confidential information shall be kept on computers protected by coded, individual passwords and located in a secured area. Transfer of records onto removable electronic media shall occur only if absolutely necessary for HIV surveillance program operations and shall be authorized by the HIV confidentiality officer. The records shall always be encrypted before the transfer to the removable media. Exchange of HIV confidential information using electronic mail shall be done only if encryption procedures are utilized.
- (f) HIV confidential information shall be permanently removed from HIV records as soon as the information is no longer necessary for the purposes of the control of HIV infection.
- (g) Mail containing HIV confidential information shall not include on the envelope or address any reference to the HIV infection, to the HIV virus, or to AIDS.
- (h) All telephone conversations in which HIV confidential information is exchanged shall be conducted in a manner that prevents the conversations from being overheard by unauthorized persons.
- (i) Each public health agency shall adopt and implement a written security policy related to HIV confidential information consistent with the provisions of this regulation. A copy of the security policy shall be distributed to all authorized personnel.
- (j) Access to HIV confidential information shall be restricted to a minimum number of authorized personnel trained in confidentiality procedures and aware of penalties for the unauthorized disclosure of HIV confidential information. The HIV confidentiality officer shall authorize the persons who may have access to HIV confidential information and shall keep a list of authorized personnel.
- (k) A confidentiality agreement shall be signed by each person authorized to access HIV confidential information. The HIV confidentiality officer shall maintain a copy of the confidentiality agreement for all authorized personnel.

(l) HIV confidential information shall not be cross-matched with records in other data bases if the resulting cross-matched data bases do not have equivalent security and confidentiality protections, and penalties for unauthorized disclosure as those for the HIV confidential information.

(m) The use of records containing HIV confidential information for research purposes shall be approved by institutional review boards, and all researchers shall sign confidentiality statements. Information made available for epidemiologic analyses shall not include names or other HIV confidential information and shall not result in the direct or indirect identification of persons reported with HIV and AIDS.

(n) Any security breach of HIV confidential information shall be investigated by the HIV confidentiality officer, and personnel sanctions and criminal penalties shall be imposed as appropriate. The HIV confidentiality officer shall make an immediate telephone notification to the secretary that a breach of HIV confidential information occurred and shall transmit to the secretary a written report within seven days from the time the breach is discovered.

(o) The provisions contained in this regulation shall apply to all individuals required to send HIV reports to the secretary under K.S.A. 65-6002, and amendments thereto, and to counseling and testing sites that receive funds from public health agencies.

Authorized by K.S.A. 65-101, 65-128, and 65-6003, as amended by L. 1999, ch. 109, sec. 3; implementing K.S.A. 65-128 and K.S.A. 1998 Supp. 65-6002, as amended by L. 1999, ch. 109, sec. 2; effective Feb. 18, 2000.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 4. MATERNAL AND CHILD HEALTH SCREENING OF NEWBORN INFANTS**

28-4-501. Definitions.

(a) "Birth attendant" means the person assisting with an out-of-institution delivery of the infant, in the absence of a physician.

(b) "Borderline hypothyroid" means an abnormally low level of thyroxine and a higher than normal level of thyroid-stimulating hormone in the blood, the combination of which is not usually indicative of hypothyroidism.

(c) "Department" means the Kansas department of health and environment.

(d) "Galactosemia" means the disease of genetic origin due to galactose uridyl transferase enzyme deficiency in which the individual is completely or partially incapable of normal metabolism of galactose, which results in an abnormal increase in the concentration of galactose in the blood.

(e) "Hemoglobin disease" means the presence of abnormal hemoglobin and the absence of adult hemoglobin, the combination of which is indicative of disease and requires ongoing medical treatment.

(f) "Hemoglobin trait" means the presence of abnormal hemoglobin, which is not indicative of disease and does not usually require ongoing medical treatment.

(g) "Hypothyroidism" means a congenital disease in which the individual is unable to produce thyroxine normally, which may be detected by an abnormally low serum level of thyroxine and an abnormally high serum level of thyroid-stimulating hormone in the blood. For purposes of these newborn screening regulations, this definition shall exclude diseases referred to as secondary hypothyroidism.

(h) "Institution" means a hospital or other organized agency providing obstetrical services.

(i) "Kit" means the multiple-page laboratory requisition with the attached filter paper to be used for blood collection and with a place for identifying the infant, physician, and sending agency data. The kits shall be provided by the department.

(j) "Laboratory" means the division of health and environmental laboratories, Kansas department of health and environment.

(k) "Medical specialist" means a medical doctor who has training in the treatment of a specific disease entity and who is on contract with the Kansas department of health and environment to serve as a consultant and to provide or direct diagnosis and treatment services.

(l) "Newborn screening coordinator" means the designee in the department of health and environment providing the follow-up program activities.

(m) "Other genetic disease" means any condition inherited in a recognized pattern that may be detected in a filter paper blood specimen and that the secretary has designated as part of the newborn screening battery of tests.

(n) "Phenylketonuria" means any disease, usually due to a single enzyme deficiency of genetic origin, in which the individual is completely or partially incapable of normal metabolism of phenylalanine, which results in an abnormal increase in the concentration of phenylalanine in the blood.

(o) "Presumptive positive" means a screening test result that indicates the possible presence of the disease, requiring further testing to confirm or not confirm the diagnosis.

(p) "Secretary" means the secretary of the Kansas department of health and environment.

(q) "Sending agency" means the agency or person identified on the kit to be the recipient of the report.

(r) "Specimen" means the saturated blood spots on the filter paper and the laboratory requisition with complete identifying data on the infant, physician, and sending agency.

Authorized by K.S.A. 65-101; implementing K.S.A. 1999 Supp. 65-181; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987; amended April 14, 2000.

28-4-502. Responsibility to obtain specimen.

(a) The administrative officer or other person in charge of each institution or the attending physician are responsible for obtaining an adequate initial specimen for newborn screening on infants born in that institution.

(b) The attending physician or other birth attendant is responsible for obtaining an adequate specimen for newborn screening on infants born outside of an institution.

(c) The attending physician or other birth attendant is responsible for obtaining repeat specimens when needed to complete the screening process.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-181; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987.

28-4-503. Timing of specimen collection.

(a) Initial specimens from healthy full-term infants born in an institution shall be obtained before discharge or from three through five days of age if the infant is still hospitalized.

(b) Initial specimens from sick or premature infants born in an institution shall be obtained from seven through 10 days of age if the infant is still hospitalized or before discharge, if earlier than seven days.

(c) If the infant is transferred from the institution of birth to another institution before 24 hours of age, the receiving institution shall obtain the specimen.

- (d) Specimens shall be obtained before blood transfusions, regardless of the age of the infant.
- (e) Initial specimens from infants born outside of an institution shall be obtained from three through five days of age.
- (f) Repeat screening of or diagnostic test specimens from infants shall be obtained before 21 days of age.
- (g) If an infant is less than 24 hours old when the initial specimen is taken, a repeat specimen shall be obtained and submitted for testing to the laboratory.

Authorized by K.S.A. 65-101; implementing K.S.A. 1999 Supp. 65-181; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987; amended April 14, 2000.

28-4-504. Methods of specimen collection.

- (a) The specimen shall be collected using kits provided by the department.
- (b) The form provided with the kit shall be completed before collection of the blood specimen.
- (c) The outlined circles on the filter paper portion of the kit shall be saturated with blood in the manner specified on the filter paper.
- (d) The specimen shall be delivered by carrier or mailed first-class to the laboratory after the blood has dried and not later than 24 hours from time of collection.

Authorized by K.S.A. 65-101; implementing K.S.A. 1998 Supp. 65-181; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987; amended April 14, 2000.

28-4-505. Unsatisfactory specimens.

- (a) Unsatisfactory specimens shall be retained by the department. The sending agency or facility shall be notified that the specimen is unsatisfactory. The physician shall be notified that the specimen is unsatisfactory with a request to submit another specimen.
- (b) Specimens shall be labeled unsatisfactory when one of the following criteria is met:
 - (1) Identifying information is missing.
 - (2) More than 10 days have elapsed since the date of collection.
 - (3) The specimen is of unacceptable quality for analysis.

Authorized by K.S.A. 65-101; implementing K.S.A. 1998 Supp. 65-181; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987; amended April 14, 2000.

28-4-509. Registry.

- (a) The registry shall be a computerized data system that includes the diagnosed individuals' name, birth-date, unique identification number, diagnosis, address including telephone number, parental names and addresses, guardian, nuclear family size and health status.

(b) Persons or guardians of minor children with a confirmed diagnosis of phenylketonuria, hypothyroidism or galactosemia shall forward to the newborn screening coordinator any address and health status changes within three months of the change.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-180; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987.

28-4-510. Treatment.

(a) Persons with a confirmed diagnosis shall be eligible to receive treatment products and medical specialist monitoring upon an annual receipt of the person's current address, insurance data and documentation of continued medical need from a medical specialist. These treatment services are at no cost to the individual.

(b) Medical specialists for phenylketonuria, hypothyroidism and galactosemia shall:

(1) provide consultation and diagnosis; and

(2) provide and coordinate ongoing treatment and control clinics.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-180; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987.

28-4-511. Test refusal. Refusal to take part in the testing procedure shall be documented in the child's record at the institution or physician's office or both.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-182; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987.

28-4-512. Parental education.

(a) Providers of prenatal health care shall discuss and distribute written material describing the newborn screening program as a component of the prenatal care to pregnant women.

(b) Prior to obtaining the specimen for newborn screening, the person responsible for obtaining the specimen shall inform the parent or parents about the newborn screening program, including how the test can be refused.

Authorized by K.S.A. 65-101; implementing K.S.A. 65-182; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987.

28-4-513. Professional education.

(a) Consultation with medical specialists shall be available without charge to primary care providers and others involved in the care of persons at risk for or diagnosed with phenylketonuria, congenital hypothyroidism, galactosemia, or hemoglobin diseases and traits.

(b) Notification letters and telephone calls reporting abnormal test results to the physicians shall contain information including interpretation of data and recommendations for follow-up.

(c) Upon request, workshops and other educational presentations concerning newborn screening shall be provided by the department when a specific need is identified.

(d) The newborn screening coordinator and personnel in the newborn screening section of the laboratory shall respond to telephone and written inquiries concerning specimens within five working days of receipt.

Authorized by K.S.A. 65-101; implementing K.S.A. 1998 Supp. 65-180; effective, T-87-48, Dec. 19, 1986; effective May 1, 1987; amended April 14, 2000.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 17. DIVISION OF VITAL STATISTICS**

28-17-6. Fees for copies, abstracts, and searches.

- (a) (1) Subject to the restrictions of K.S.A. 65-2417, K.S.A. 65-2418, and K.S.A. 65-2423, and amendments thereto, certified copies or abstracts of certificates or parts of certificates shall be furnished by the state registrar upon request by an authorized applicant and payment of the required fee.
- (2) The fees for making and certifying copies or abstracts of birth, delayed birth, fetal death, marriage, and divorce certificates shall be \$ 12.00 for the first copy or abstract and \$ 7.00 for each additional copy or abstract of the same record requested at the same time. The fees for making and certifying copies or abstracts of death certificates shall be \$ 13.00 for the first copy or abstract and \$ 8.00 for each additional copy or abstract of the same record requested at the same time.
- (b) For any search of the files and records for birth, delayed birth, fetal death, marriage, and divorce when no certified copy or abstract is made, the fee shall be \$ 12.00 for each five-year period for which a search is requested, or for each fractional part of a five-year period. For any search of files and records for death when no certified copy or abstract is made, the fee shall be \$ 13.00 for each five-year period for which a search is requested, or for each fractional part of a five-year period.
- (c) For any search of the files necessary for preparing an amendment to a standard birth, fetal death, marriage, or divorce certificate or abstract already on file, the fee shall be \$ 12.00. For any search of the files necessary for preparing an amendment to a death certificate or abstract already on file, the fee shall be \$ 13.00.
- (d) For non-certified copies or abstracts of certificates or parts of certificates requested for statistical research purposes, the fee and manner in which the fee is to be paid shall be determined by the state registrar on the basis of the costs for providing those services.

Authorized by K.S.A. 65-2418, as amended by 2003 HB 2423, Sec. 2; implementing K.S.A. 2002 Supp. 23-110, K.S.A. 65-2417, K.S.A. 65-2418, as amended by 2003 HB 2423, Sec. 2, and K.S.A. 65-2420; effective Jan. 1, 1966; amended Jan. 1, 1968; amended, E-78-18, July 7, 1977; amended May 1, 1978; amended May 1, 1983; amended, T-84-13, July 1, 1983; amended May 1, 1984; amended May 1, 1988; amended Oct. 7, 1991; amended, T-28-9-25-92, Sept. 25, 1992; amended Nov. 16, 1992; amended Aug. 16, 1993; amended, T-28-7-2-01, July 2, 2001; amended Oct. 12, 2001; amended, T-28-6-27-02, July 1, 2002; amended Oct. 18, 2002; amended, T-28-7-1-03, July 1, 2003; amended Oct. 17, 2003.

28-17-9. Approval of application for delayed birth certificate. Each application for a delayed birth certificate, including completed forms, as required, and documentary evidence, shall be examined, abstracted, and filed or rejected only in the office of vital statistics of the department.

Authorized by K.S.A. 65-2402; implementing 65-2420; effective Jan. 1, 1966; amended May 1, 1986.

28-17-10. Application form requirements for registration of delayed birth certificate. Requirements for registration of a delayed birth certificate shall be the following: The delayed birth certificate shall be filled out giving facts as at the time of birth, signed before a notary public, or person duly authorized to administer oath, by the registrant if over 18 years of age. If under age 18, the delayed certificate shall be signed by the parent, older relative or attending physician. The delayed birth certificate shall be supported by the following evidence:

- (1) Two original documents or certified or photostatic copies of original documents executed at least five years prior to date of application for delayed birth certificate which show date of birth or age, birthplace and parents' names, (except that documentary evidence may be waived in cases where the registrant is under 12 years of age at the time application is made.)

Plus

- (2) At least two affidavits sworn by two of the following: Attending physician, midwife, parent, householder or other older relatives attesting to the facts of the birth as alleged on the delayed birth certificate: Provided, That additional documentary evidence may be substituted for one or both affidavits whenever the latter are unobtainable. The affiants in all cases must be at least five years older than the registrant.

Authorized by K.S.A. 65-2402, 65-2419, 65-2420; effective Jan. 1, 1966.

28-17-11. Disposition of supporting documents for delayed birth certificate registration. All supporting evidence or affidavits will be examined and abstracted by the state registrar or his deputy on the face of the certificate, and the evidence, or original or certified copies will be returned to the registrant.

Authorized by K.S.A. 65-2419, 65-2420; effective Jan. 1, 1966.

28-17-12. Delayed birth certificate filing fee. Each application for a delayed birth certificate shall be accompanied by a fee in the amount of \$ 10.00 for the filing and registration of the delayed birth certificate. A certified copy may be issued in accordance with K.A.R. 28-17-6 and any amendments to that rule and regulation.

Authorized by and implementing K.S.A. 65-2420; effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1983; amended Oct. 22, 1990; amended Oct. 7, 1991; amended, T-28-9-25-92, Sept. 25, 1992; amended Nov. 16, 1992.

28-17-13. Maternity home, clinic and hospital reports. Each person in charge of a maternity home, clinic or hospital shall report to the department on or before the fifth day of each month a complete list of births and stillbirths that occurred in the institution during the preceding calendar month. The list shall include the child's name and date of birth, and the name of the attending physician and shall be submitted on a form provided by the department.

Authorized by K.S.A. 65-2402; implementing K.S.A. 65-2425; effective Jan. 1, 1966; amended May 1, 1986.

28-17-14. Required records of institutions. It shall be the duty of the state registrar, or his duly authorized agents, to inspect the records of all hospitals and other institutions, both public and private, as often as in the judgment of the state registrar it may be necessary to do so.

All hospitals and institutions shall keep a record of personal particulars and data concerning each person admitted or confined to such hospital or other institution. This record shall include such information as required by the standard certificate of birth, death, and stillbirth forms issued under the provisions of this act. The record shall be made at the time of admission from information provided by such person, but when it cannot be so obtained, the same shall be obtained from relatives or other persons acquainted with the facts. The name and address of the person providing the information shall be a part of the record.

Authorized by K.S.A. 65-2402, 65-2425; effective Jan. 1, 1966.

28-17-15. State registrar to prescribe forms. All paper or electronic forms used in registering, recording, and preserving the records shall be prescribed by the department. Each local registration officer shall accept and use only forms prescribed by the state registrar and shall issue out-of-state transit permits only when the proper forms are used and completed.

Authorized by K.S.A. 65-2402; implementing K.S.A. 65-2415; effective Jan. 1, 1966; amended May 1, 1986; amended Oct. 22, 1990; amended, T-28-4-25-00, April 25, 2000; amended Aug. 4, 2000.

28-17-19. Unattended births. Additional information for each unattended birth shall be submitted to the office of vital statistics for inclusion on the original birth certificate within 90 days of the date the birth certificate is filed with the office of vital statistics. If an unattended birth is not registered within six months of the date of birth, a delayed birth certificate shall be filed in accordance with K.S.A. 65-2419 and K.S.A. 65-2420, K.A.R. 28-17-8, K.A.R. 28-17-9, K.A.R. 28-17-10, K.A.R. 28-17-11 and K.A.R. 28-17-12.

Authorized by K.S.A. 65-2402; implementing K.S.A. 65-2410, as amended by L. 1990, Chap. 226; effective Jan. 1, 1966; amended May 1, 1987; amended Oct. 22, 1990.

28-17-20. Corrections to certificates and records. Corrections to certificates or records may be made only as follows and only within the time limit indicated in each subsection.

(a) Amendments within 90 days.

(1) Within 90 days of receipt of an original vital record in the office of vital statistics, the following records in which an inaccuracy or incomplete item is apparent on the face of the certificate, may be changed to show the accurate and complete facts:

(A) birth certificates;

(B) any part of a death certificate other than the portion describing the cause of death;

(C) stillbirth certificate; and

(D) divorce records.

(2) Such changes shall be made in one of two ways:

(A) drawing a single line through the incorrect information, inserting the correct information in the appropriate space, and placing the date of the amendment and the word "amended" on the record. This process shall be the primary way in which amendments are made and this process of amendment shall not be used more than one time for the same item; or

(B) completing a new certificate in accordance with K.S.A. 38-1130 and amendments thereto, or completing a new certificate when a single line has been previously drawn through incorrect information. The date of the amendment and the word "amended" shall be placed on the newly created certificate. This process of amendment shall not be used more than one time for the same item.

(3) An amendment fee shall not be required for changes made within the first 90 days after receipt of the vital record in the office of vital statistics.

(b) Amendments after 90 days. After 90 days of receipt of the vital record in the office of vital statistics, amendments may be made only as follows:

(1) Certificates of birth.

(A) Birth certificate items may be amended upon the applicant's submission of at least two documents which consistently substantiate the item or items to be amended and that are executed and dated at least five years prior to the request for the amendment or prior to the tenth birthday anniversary of the registrant, except that items (i) through (viii) shall be corrected only as provided.

(i) The items recording the registrant's sex may be amended if the amendment is substantiated with the applicant's affidavit that the sex was incorrectly recorded or with a medical certificate substantiating that a physiological or anatomical change occurred.

(ii) If the registrant is a minor, any request by the parents to change an item by adding the name of a parent, correcting the name of either parent or of the child, or changing the child's last name to that of either parent shall be made only pursuant to K.S.A. 38-1130 and amendments thereto.

(iii) Any registrant who is of legal age may amend the order of the registrant's given names if the amendment is substantiated with one of the documents specified in paragraph (A) above.

(iv) A registrant who is of legal age may place a given name or names of the registrant on the record only if there is no given name on the original certificate and if the amendment is substantiated with one of the documents specified in paragraph (A) above.

(v) A registrant who is of legal age may correct a given name or names of the registrant if the amendment is substantiated with one document established prior to the seventh birthday anniversary of the registrant.

(vi) A registrant who is of legal age may correct the spelling of the last name of the registrant if the amendment is substantiated with two documents established prior to the seventh birthday anniversary of the registrant. A registrant who is of legal age may not change the last name of the registrant under authority of this regulation.

(vii) A registrant who is of legal age may correct the maiden name of the mother or the legal name of the father or mother, or the legal name of the father and mother of the registrant, if one of the required documents specified in paragraph (A) above is the marriage license or birth certificate of that parent.

(viii) The birth date on the certificate may only be changed if both required documents were executed and dated prior to the seventh birthday anniversary, and if the change is not inconsistent with the recorded filing date.

(B) When an amendment is made after 90 days, any item that has been previously amended shall not be changed under authority of this regulation.

(C) The sufficiency of affidavits and supporting evidence shall be determined by the state registrar.

(D) Requests for an amendment to a certificate of birth that do not require a court order shall be submitted by the parent or legal guardian of persons not of legal age, or by the person whose birth is recorded, if of legal age, and by none other. The person submitting such an application shall execute a notarized affidavit stating the true facts to be recorded.

(E) When amendments to a birth certificate are made after 90 days of the date the certificate was received by the office of vital statistics, the original certificate shall remain unchanged and placed in a sealed file to be opened only by court order. A new certificate shall be prepared and shall be marked "amended." The date of the amendment shall be recorded on the certificate. In the sections where the original certificate contained a signature, the amended certificate shall contain the typed name of the person who signed. The original certificate and any affidavit required shall be permanently filed by the office of vital statistics.

(2) Certificates of death--personal data.

(A) "Personal" data may be amended if the request is made within the first six months after the filing of the original certificate.

(B) Requests for amendments to "personal" data may be made only by the funeral director or person acting as such who submitted the original certificate.

(C) When amendments to the "personal" data of a death certificate are made after 90 days of the date the certificate is received in the office of vital statistics, the original certificate shall remain on file unchanged and placed in a sealed file to be opened only by court order. A new certificate shall be prepared by the funeral director or person acting as such. The medical certification section shall again be completed and the required signatures shall be secured in all possible instances. The signatures may be typed if the required signatures are unattainable and a written statement of the reason therefore is attached to the certificate. The certificate shall not be accepted if the stated reason for the typed signature is inadequate. Upon acceptance by the office of vital statistics, the new certificate shall be marked "amended" and shall indicate the date of the amendment.

(c) Amendments, no time limit.

(1) Certificate of death--medical certification.

(A) An amendment may be made to the medical certification data at any time.

(B) Requests for amendments to the medical certification data may be made only by the attending physician who signed the medical certification on the original certificate, or by the coroner in whose jurisdiction the death occurred.

(C) Amendments to the medical certification may be made in one of two ways:

(i) the original certificate shall remain on file unchanged, and the written statement or affidavit of the certifying physician or coroner shall be appended to the back of the original certificate; or

(ii) a certifying physician or coroner may request the establishment of a new death certificate when erroneous data has been entered in the medical certification section. In such a case, the funeral director or person acting as such shall enter the personal data and refer the certificate to the certifying physician or coroner for the medical certification and signature. When all items have been completed, the new certificate shall be submitted to the office of vital statistics and upon its acceptance, it shall be marked "amended" and shall indicate the date of the amendment. The original death record shall be placed in a sealed file only to be opened by court order.

Authorized by K.S.A. 65-2402 and implementing K.S.A. 65-2422c; effective Jan. 1, 1966; amended May 1, 1987; amended May 1, 1988; amended Oct. 22, 1990; amended, T-28-9-25-92, Sept. 25, 1992; amended Nov. 16, 1992; amended Aug. 16, 1993.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 34. HOSPITALS**

28-34-1a. Definitions.

(a) "Authenticate" means to verify authorship by written signature, identifiable initials, or computer key. The use of rubber stamp signatures shall be acceptable if the following conditions are met.

(1) The practitioner whose signature the rubber stamp represents is the only individual who has possession of the stamp and who uses the stamp.

- (2) The hospital maintains, in its administrative offices, a signed statement by the practitioner indicating that the practitioner is the only person who possesses and uses the stamp.
- (b) "Chief executive officer" means the individual appointed by the governing body to act on its behalf in the overall management of the hospital.
- (c) "Consultant" means a person who provides professional advice or services on request.
- (d) "Covering practitioner" means a member of the hospital's medical staff who is authorized by the patient's attending physician or other practitioner to provide care and treatment for the patient in the absence of the attending physician or other practitioner.
- (e) "Dentist" means a person licensed in Kansas to practice dentistry.
- (f) "Dietitian" means a person who is licensed in Kansas as a dietitian.
- (g) "Dietetic services supervisor" means an individual who meets one of the following requirements:
- (1) Is licensed in the state of Kansas as a dietitian;
 - (2) has an associate's degree in dietetic technology from a program approved by the American dietetic association;
 - (3) is a dietary manager who is certified by the board of the dietary managers' association; or
 - (4) has training and experience in dietetic services supervision and management that are determined by the secretary of health and environment to be equivalent in content to paragraph (2) or (3) of this subsection.
- (h) "Director" means a person with administrative responsibility for the direction of a service for the hospital. When this term is used in connection with a medical or clinical service, it shall be synonymous with "chairperson" and shall not imply a salaried individual.
- (i) "Drug administration" means the direct application of a drug or biological, whether by injection, inhalation, ingestion, or any other means, to the body of a patient by either of the following:
- (1) A practitioner, or pursuant to the lawful direction of a practitioner, who is acting within the scope of that practitioner's license and who is qualified according to medical staff bylaws; or
 - (2) the patient at the direction and in the presence of a practitioner.
- (j) "Drug dispensing" means delivering prescription medication to the patient pursuant to the lawful order of a practitioner.
- (k) "Facilities" means buildings, equipment, and supplies necessary for the implementation of hospital services.
- (l) "Licensed practical nurse" means an individual who is licensed in Kansas as a licensed practical nurse.
- (m) "Licensing agency" means the Kansas department of health and environment.
- (n) "Long-term care unit" means a unit that provides physician services and continuous nursing supervision for patients who are not in an acute phase of illness and who currently require nursing care that is primarily of a convalescent, restorative, or long-term nature. Medicare-certified, distinct-part, long-term care units shall be included.
- (o) "Nursing care unit" means an organized jurisdiction of nursing services in which nursing services are provided on a continuous basis.

(p) "Nursing services" means patient care services pertaining to the curative, restorative, and preventive aspects of nursing that are performed or supervised by a registered nurse pursuant to the medical care plan of the practitioner and the nursing care plan.

(q) "Organized" means administratively and functionally structured.

(r) "Organized medical staff" means a formal organization of physicians and dentists, with the responsibility and authority to maintain proper standards for patient care as delegated by the governing body.

(s) "Outpatient services" means an organizational unit of the hospital that is designed to support the provision of nonemergency health care services to patients who do not remain in the hospital overnight. The term shall include a short-term procedure unit if applicable.

(t) "Pathologist" means either of the following:

(1) A person who is licensed in Kansas to practice medicine and surgery and who is a board-certified or board-eligible pathologist; or

(2) a person licensed in Kansas as a dentist and certified as an oral pathologist.

(u) "Patient" means a person admitted to the hospital upon the order of a member of the medical staff.

(v) "Physician" means a person licensed in Kansas to practice medicine and surgery.

(w) "Practitioner" means a member of the hospital's medical staff and may include a physician or dentist.

(x) "Qualified nurse anesthetist" means any of the following:

(1) A registered nurse who has been certified as a nurse anesthetist by the council on certification of the American association of nurse anesthetists and has been authorized as a registered nurse anesthetist by the Kansas board of nursing;

(2) a student enrolled in a program of nurse anesthesia by the council on accreditation of the American association of nurse anesthetists; or

(3) a graduate of an accredited program of nurse anesthesia who is awaiting certification testing or the results of the certification test and has been granted temporary authorization as a registered nurse anesthetist by the Kansas state board of nursing.

(y) "Registered nurse" means a person who is licensed in Kansas as a registered professional nurse.

(z) "Service" means either of the following:

(1) A functional division of the hospital or of the nursing or medical staff; or

(2) the delivery of care.

(aa) "Supervision" means authoritative procedural guidance provided by a qualified person for the accomplishment of a function or activity within that person's sphere of competence. Supervision shall include initial direction and periodic inspection of the actual act of accomplishing the function or activity.

(bb) "Survey" means the process of evaluation or re-evaluation of a hospital's compliance with this article.

Authorized by and implementing K.S.A. 65-431; effective June 28, 1993; amended Feb. 9, 2001; amended Nov. 26, 2001.

28-34-2. Licensing procedure. Each applicant for an initial license to operate a hospital shall file an application on forms provided by the licensing agency at least 90 days prior to admission of patients. A license previously issued shall be renewed after the licensee has filed an annual report and the licensing agency has approved the same. The licensing agency shall approve the renewal after it has documented that the applicant is in substantial compliance with these regulations. Each application for license renewal shall be filed with the licensing agency at least 90 days before the expiration date of the current license, and the annual report shall be filed no later than 60 days after the beginning of each calendar year. The annual report may include information relating to:

- (1) Administration and ownership;
- (2) classification;
- (3) allocation of beds;
- (4) special care services;
- (5) patient statistics;
- (6) surgical facilities, services and procedures;
- (7) outpatient and emergency room services; and
- (8) staff personnel.

(b) New construction, alterations or renovations that provide space for patient services or patient rooms shall not be used until authorization has been received from the licensing agency. The licensing agency may give such authorization orally or by telephone and shall provide the facility with written confirmation within 30 days.

(c) The license shall authorize a facility to operate only the number and classifications of beds that appear on the previous license application unless additional beds or reclassification of beds have been approved in accordance with K.A.R. 28-34-32a.

(d) If the facility is found to be in violation of any of these regulations, the licensing agency shall notify the applicant in writing of each violation and require that a plan of correction be submitted before a license is issued or renewed. The plan shall state specifically what corrective action will be taken and the date on which it will be accomplished.

(e) If during the term of its current license a facility is surveyed by the joint commission on accreditation of health care organizations (JCAHO) or the American osteopathic association (AOA), the facility shall submit the survey report to the licensing agency toward satisfying the survey requirements for licensure. After reviewing the survey report, the licensing agency may notify the facility that a licensing survey will be conducted.

(f) The licensing agency will document the extent of the facility's compliance with these regulations in at least one of the following ways:

- (1) The statement of a responsible, authorized administrator or staff member;
- (2) documentary evidence of compliance provided by the facility;
- (3) answers by the facility to detailed questions provided by the licensing agency concerning the implementation of any provisions of these regulations or examples of such implementation which will enable a judgment about compliance to be made;
- (4) on-site observations by surveyors; or

(5) interviews with patients, employees or other persons or sources capable of providing reliable information.

Authorized by K.S.A. 65-428 and K.S.A. 65-431; implementing K.S.A. 65-428; K.S.A. 65-429 and 65-431; effective Jan. 1, 1969; amended Jan. 1, 1974; amended May 1, 1980; amended June 28, 1993.

28-34-3a. General requirements.

(a) Patient limits. The number of patients admitted to any area of the hospital shall not exceed the number for which the area is designed, equipped, and staffed, except in cases of an emergency. In an emergency, patients shall be admitted in accordance with the emergency or disaster plan of the hospital.

(b) Emergency electrical service. Each hospital shall have an emergency source of power to provide electricity during an interruption of the normal electrical supply. The source of this emergency electrical service shall be:

(1) An emergency generating set when the normal service is supplied by one or more central station transmission lines; or

(2) An emergency generating set or a central station transmission line when the normal electrical supply is generated on the premises.

(c) Emergency electrical system. The emergency electrical system shall include a life safety branch and a critical branch. The life safety branch shall serve illumination, alarm, and alerting equipment which shall be operable at all times for protection of life during emergencies. The critical branch shall serve lighting and receptacles in critical patient care areas.

(d) Vital statistics. Each hospital shall comply with vital statistics statutes and regulations regarding the completion and filing of birth, death, and fetal death certificates within a specified period of time.

(e) Smoking. Smoking may be permitted only in designated areas. Patients shall have the right to choose to be assigned to a room in which smoking is not permitted. Smoking shall be prohibited in all other areas that are used for patient treatment or diagnosis. The hospital shall establish written rules regarding smoking within the hospital. Rules shall be posted where they can be observed by the hospital staff and the public. Smoking shall be prohibited in any room or area where flammable liquid, combustible gas, or oxygen is being stored or used and in any other hazardous area of the hospital. Patients classified as not mentally or physically responsible for their actions shall be prohibited from smoking unless constant supervision is provided. The sale of any tobacco products shall be prohibited in any area of the hospital.

(f) Internal disaster plan. The hospital shall establish a workable plan with the nearest fire department for fire fighting service. The hospital shall provide the fire department with a current floor plan of the building. The floor plan shall show the location of fire fighting equipment, exits, patient rooms, places where flammable and explosive gases are stored, and any other information that the fire department requires. The hospital shall also develop an internal disaster and fire plan incorporating evacuation procedures. These plans shall be made available to all personnel and shall be posted throughout the building. Each employee shall participate in the duties delegated to them under the safety program and shall be instructed in the operation of the fire warning system, the proper use of fire fighting equipment, and the procedure to follow in the event that electrical power is impaired.

(g) External disaster plan. The hospital shall establish written plans, based on its capabilities, for the proper and timely care of casualties arising from external disasters. The disaster plan shall be developed in conjunction with other emergency facilities in the community so that adequate logistical provisions are made for the expansion of the activities of the hospital in coordination with the activities of other facilities. The external disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills shall involve professional, administrative, nursing, and other hospital personnel. A written report and evaluation of all drills shall be maintained for at least two years.

Authorized by and implementing K.S.A. 65-431; effective May 1, 1986.

28-34-3b. Patient rights.

(a) Policies and procedures. The governing body shall ensure that the facility establishes policies and procedures which support the rights of all inpatients and outpatients. At a minimum, each facility shall ensure that:

- (1) Each patient has the right to respectful care given by competent personnel;
- (2) each patient has the right, upon request, to be given the name of his attending physician, the names of all other practitioners directly participating in his care and the names and functions of other health care persons having direct contact with the patient;
- (3) each patient has the right to make health care decisions. Each patient has the right to the information necessary to make treatment decisions reflecting the patient's wishes and to request a change in his physician or transfer to another health facility due to religious or other reasons;
- (4) each patient has the right to accept medical care, to refuse treatment to the extent permitted by state law and to be informed of the medical consequences of refusing treatment;
- (5) each patient has the right to formulate advance directives and appoint a surrogate to make health care decisions on the patient's behalf to the extent permitted by law;
- (6) each patient has the right to assistance in obtaining consultation with another physician or practitioner at the patient's request and own expense;
- (7) each patient has the right to hospital services without discrimination based upon his race, color, religion, sex, national origin or source of payment;
- (8) each patient or patient's legally designated representative has access to the information contained in the patient's medical records within the limits of state law;
- (9) each patient has the right to examine and receive a detailed explanation of the patient's bill; and
- (10) each patient is informed of the facility's policies regarding patient rights during the admission process.

(b) Grievances. The facility's policies and procedures shall establish a mechanism for responding to patient complaints.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-4a. Visitors.

(a) Each hospital shall establish visitation policies which are in the interest of the patients. Children under 12 years of age shall not be admitted as visitors to the hospital except in the company of a responsible adult. Children under six years of age shall be admitted as visitors only when the hospital has a special family visiting program or when authorized in writing by the attending physician, or the chief executive officer of the hospital, or the professional nurse charged with the responsibility for the care of the patient.

(b) Each hospital shall post visiting regulations in a location where they can be easily viewed by the public.

Authorized by and implementing K.S.A. 65-431; effective May 1, 1986.

28-34-5a. Governing authority.

(a) Governing body. Each hospital shall have an organized governing body. The governing body shall be the ultimate authority in the hospital responsible for its organization and administration in a manner which is consistent with appropriate standards of patient care, environmental safety and institutional management.

(b) Bylaws. The governing body shall adopt its own set of bylaws. At a minimum, the bylaws shall contain the following provisions:

- (1) A statement of the mission of the hospital;
- (2) a description of the powers and duties of the governing body, officers and committees and of the responsibilities of the chief executive officer;
- (3) a statement of the qualifications for governing body membership, the procedures for selecting members and the term for members, officers and committee chairpersons;
- (4) a description of the authority delegated to the medical staff;
- (5) a requirement that the governing body review and approve the bylaws of the medical staff organization;
- (6) a requirement that the governing body approve or deny all applications for medical staff membership and for the granting of clinical and admitting privileges; and
- (7) a description of the mechanism by which the governing body bylaws are adopted, reviewed and revised.

(c) Functions. At a minimum, the governing body shall:

- (1) Provide adequate physical resources and personnel for appropriate patient care;
- (2) participate in planning to define and help meet the health needs of the community;
- (3) formulate short-term and long-term plans for the development of the hospital;
- (4) review the annual audit of the financial operations of the hospital;
- (5) maintain effective communication with the medical staff;
- (6) require the medical staff to establish controls that are designed to achieve and maintain appropriate standards of ethical professional practice;
- (7) establish a structure to effectively fulfill the governing body's responsibilities and to evaluate the implementation of programs and policies;
- (8) maintain a written record of governing body proceedings; and
- (9) implement and maintain a risk management program in accordance with K.S.A. 65-4291 et seq.

(d) Conflict of interest. Members of the governing body shall not maintain personal or business interests which conflict with those of the hospital to an extent deemed by the governing body to present a threat of injury to or loss of the hospital's reputation, assets or ability to provide patient care.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-6a. Medical staff.

(a) General provision. Each hospital shall maintain an organized medical staff. Admission to the staff and clinical privileges associated with membership shall be granted by the governing authority through a mechanism that evaluates each member's qualifications to engage in that member's area of clinical practice. Admitting privileges may be granted to any practitioner as defined in K.A.R. 28-34-1a(w).

(b) Membership. The medical staff shall be limited to practitioners who have made application in accordance with the bylaws of the medical staff and the governing body. The medical staff shall adopt bylaws that define the requirements for admission to staff membership and for the delineation and retention of clinical and admitting privileges. Each member shall be granted privileges that are commensurate with the member's qualifications, experience, and present capabilities and that are within the member's scope of practice. Although certification, fellowship, membership on a specialty board or society, or the completion of a general practice residency may be considered in determining an individual's qualifications for medical staff membership, membership decisions shall not be made solely upon any one of these factors.

(c) Medical staff status.

(1) Each hospital shall have an active medical staff to deliver the preponderance of medical services within the hospital. The active medical staff shall have primary responsibility for the organization and administration of the medical staff. Each member of the active medical staff shall be eligible to vote at staff meetings, hold office, and serve on staff committees.

(2) In addition to the active medical staff, the hospital may provide for additional kinds of medical staff privileges. These additional staff categories shall in no way modify the privileges, duties, and responsibilities of the active medical staff. These additional staff categories may be eligible to vote at staff meetings, hold office, and serve on staff committees.

(d) Appointment and reappointment. After considering medical staff recommendations, the governing body shall affirm, deny, or modify each recommendation for appointment to the medical staff and the granting of clinical privileges to any practitioner. Formal application for membership and for the granting of clinical privileges shall follow established procedures set forth in the bylaws, policies, and procedures of the medical staff.

(e) Medical staff bylaws, policies, and procedures. The medical staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws that shall provide for at least the following:

(1) The organizational structure of the medical staff;

(2) qualifications for staff membership and procedures for admission, retention, assignment, and either reduction or withdrawal of privileges;

(3) procedures and standards for the review of staff credentials;

(4) a mechanism for an appeal by a practitioner who receives an unfavorable medical staff recommendation;

(5) delineation of clinical privileges and duties of professional personnel who function in a clinical capacity and who are not members of the medical staff;

(6) methods for the selection of officers and department or service chairpersons and a description of their duties and responsibilities;

(7) the composition and function of standing committees;

(8) requirements regarding the completion of medical records, including a system of disciplinary action for failure to complete the records of discharged patients within 30 days after dismissal or current records within 48 hours of admission;

(9) a mechanism by which the medical staff consults with and reports to the governing body;

(10) medical staff meetings for the purpose of reviewing the performance of the medical staff and each department or service and reports and recommendations of the medical staff and multidisciplinary committees; and

(11) a mechanism for review of medical staff performance that shall include consideration of relevant ethics and statutory codes of conduct.

(f) Medical care review. The medical staff shall develop and implement a system to review medical services rendered, evaluate their quality, and provide an educational program for medical staff members. This system shall include written criteria for the evaluation of medical care that shall cover admission, length of stay, and professional services furnished and shall be conducted on at least a sample basis.

(g) Medical orders.

(1) Medication or treatment shall be administered only upon written and signed orders of a practitioner who is acting within the scope of that practitioner's license and who is qualified according to medical staff bylaws.

(2) A practitioner may give verbal orders, including telephone orders, for medication or treatment to personnel who are qualified according to medical staff bylaws. The person entering these orders into the medical record shall sign and date the entry as soon as possible. These orders shall be authenticated by the prescribing or covering practitioner within 72 hours of the patient's discharge or 30 days, whichever occurs first.

Authorized by and implementing K.S.A. 65-431; effective June 28, 1993; amended Feb. 9, 2001.

28-34-7. Nursing personnel.

(a) There shall be an organized nursing department, including a departmental plan of administrative authority with written delineation of responsibilities and duties of each category of nursing personnel.

(b) All registered nurses employed by the hospital to practice professional nursing shall be licensed in Kansas.

(c) All practical nurses employed by the hospital shall be licensed in Kansas.

(d) There shall be a director of nursing service.

(e) All licensed practical nurses and other ancillary personnel performing patient care services shall be under the supervision of a registered nurse.

(f) There shall be at least one registered nurse on duty in the hospital at all times.

(g) Nursing care policies and procedures shall be in writing and consistent with generally accepted practice and shall be reviewed and revised as necessary.

(h) Private duty nurses shall be licensed in Kansas and shall be subject to the policies, rules, and regulations of the hospital in which they are employed.

(i) Minutes shall be kept of nursing staff meetings.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-8a. Administrative services.

(a) General provisions. There shall be an adequate administrative staff to provide effective management of the hospital.

(b) The chief executive officer. The governing body shall appoint a chief executive officer. The qualifications, responsibilities, duties and authority of the chief executive officer shall be described in a written statement adopted by the governing body. The chief executive officer shall implement the policies established by the governing body for the operation of the hospital and shall act as a liaison between the governing body, the medical staff and the departments of the hospital.

(c) Personnel policies and procedures. The governing body, through the chief executive officer, shall establish and maintain written personnel policies and procedures which adequately support sound patient care. These policies and procedures shall be made available to all employees and shall be reviewed at least every two years. A procedure shall be established for advising employees of policy and procedure changes.

(d) Personnel records. Accurate and complete personnel records shall be maintained for each employee. Personnel records shall contain at least the following information for each employee:

(1) Information regarding the employee's education, training and experience that is sufficient to verify the employee's qualifications for the employee's job. The information shall indicate the employee's professional licensure status;

(2) current information regarding periodic work performance evaluations; and

(3) records of the initial health examination and of subsequent health services and periodic health evaluations.

(e) Education programs. Orientation and inservice training programs shall be provided to allow personnel to improve and maintain skills and to learn of new health care developments.

(f) Personnel health requirements. Upon employment, all hospital personnel shall have a medical examination which shall consist of examinations appropriate to the duties of the employee, including a chest X-ray or tuberculin skin test. Subsequent medical examinations or health assessments shall be given periodically in accordance with hospital policies. Each hospital shall develop policies and procedures for control of communicable disease, including maintenance of immunization histories and the provision of educational materials to the patient care staff.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-9a. Medical records services.

(a) General provisions. Each hospital shall maintain medical records for each patient admitted for care. The records shall be documented and readily retrievable by authorized persons.

(b) Organization and staffing.

(1) Each hospital shall have a medical records service that is directed, staffed, and equipped to enable the accurate processing, indexing, and filing of all medical records. The medical records service shall be under the direction of a person who is a registered health information administrator or a registered health information technician as certified by the American health information management association, or who meets the educational or training requirements for this certification.

(2) If the employment of a full-time registered health information administrator or registered health information technician is impossible, the hospital shall employ a registered records administrator or an accredited records technician on a part-time consultant basis. The consultant shall organize the department, train full-time personnel, and make periodic visits to evaluate the records. There shall be a written contract between the hospital and the consultant that specifies the consultant's duties and responsibilities.

(3) At least one full-time employee shall provide regular medical records service.

(c) Facilities. The medical records department shall be properly equipped to enable its personnel to function in an effective manner and to maintain medical records so that the records are readily accessible and secure from unauthorized use.

(d) Policies and procedures.

(1) Each medical record shall be kept on file for 10 years after the date of last discharge of the patient or one year beyond the date that the minor patient reached the age of majority, whichever is longer.

(2) If a hospital discontinues operation, the hospital shall inform the licensing agency of the location of its records.

(3) A summary shall be maintained of medical records that are destroyed. This summary shall be retained on file for at least 25 years and shall include the following information:

(A) The name, age, and date of birth of the patient;

(B) the name of the patient's nearest relative;

(C) the name of the attending and consulting practitioners;

(D) any surgical procedure and date, if applicable; and

(E) the final diagnosis.

(4) Medical records may be microfilmed after completion. If the microfilming is done off the premises, the hospital shall take precautions to assure the confidentiality and safekeeping of the records.

(5) Each record shall be treated as confidential. Only persons authorized by the governing body shall have access to the records. These persons shall include individuals designated by the licensing agency for the purpose of verifying compliance with state or federal statutes or regulations and for disease control investigations of public health concern.

(6) Medical records shall be the property of the hospital and shall not be removed from the hospital premises except as authorized by the governing body of the hospital or for purposes of litigation when specifically authorized by Kansas law or appropriate court order.

(e) Contents of medical records. Medical records shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. At a minimum, each record shall include the following:

(1) Notes by authorized house staff members and individuals who have been granted clinical privileges, consultation reports, nurses' notes, and entries by designated professional personnel;

(2) findings and results of any pathological or clinical laboratory examinations, radiology examinations, medical and surgical treatment, and other diagnostic or therapeutic procedures; and

(3) provisional diagnosis, primary and secondary final diagnosis, a clinical resume, and, if appropriate, necropsy reports.

(f) Each entry in each record shall be dated and authenticated by the person making the entry. Verbal orders, including telephone orders, shall include the date and signature of the person recording them. The prescribing or covering practitioner shall authenticate the order within 72 hours of the patient's discharge or 30 days, whichever occurs first. Records of patients discharged shall be completed within 30 days following discharge.

Authorized by and implementing K.S.A. 65-431; effective May 1, 1986; amended June 28, 1993; amended Feb. 9, 2001.

28-34-10a. Pharmacy services.

(a) General provisions. Each hospital shall provide pharmaceutical services which are administered in accordance with accepted ethical and professional practices.

(b) Organization and staffing. The pharmaceutical service shall be directed by a licensed pharmacist. If the hospital has a pharmacy, it shall be directed by a licensed pharmacist. If the hospital does not have a pharmacy or a full-time staff pharmacist, a pharmacist employed on a part-time or consultant basis shall be responsible for control and dispensing of drugs and for operation of the pharmacy or the pharmaceutical functions of nursing stations. In addition to meeting the standards in this regulation, services shall be provided in accordance with K.A.R. 68-7-11 and amendments thereto.

(c) Pharmacy facilities. Each hospital that maintains a pharmacy on its premises shall provide adequate equipment, supplies and facilities for the storage, safeguarding, preparation and dispensing of drugs. Drugs and biologicals must be kept in locked storage areas. Drugs requiring refrigeration shall be stored in conveniently located refrigerators which shall be used for drug storage only.

(d) Pharmacy and therapeutics committee. Each hospital shall establish a pharmacy and therapeutics committee or its equivalent. The committee shall consist of at least physicians, nurses and pharmacists. This committee shall assist in the formulation of broad professional policies regarding evaluation, appraisal, selection, procurement, storage, distribution and use of drugs and safety procedures and all other matters relating to drugs in the hospital. This committee shall meet at least quarterly, record its proceedings and report to the medical staff.

(e) Policies and procedures. The pharmaceutical service shall develop written policies and procedures. These policies shall be reviewed by the medical staff at least annually and shall be dated to indicate the date of last review. Procedures shall be established for the recording of all drug dispensations or other pharmacy transactions of the pharmacy or nursing stations.

(f) Medications dispensed. The hospital pharmacy shall dispense from a formulary of drugs approved by the medical staff through its appropriate committees. Any drug approved by the food and drug administration for use as an experimental drug may be used in accordance with standards established by the hospital's medical staff.

(g) Commercial pharmaceutical service. Each hospital using an outside pharmacist or pharmaceutical service shall have a contract with that pharmacist or service. As part of the contract, the pharmacist or service shall be required to maintain at least the standards for operation outlined in these regulations.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-11. Laboratory.

(a) Definitions.

(1) "CLIA" means Public Law 100-578 implemented by 42 CFR 493 issued Feb. 28, 1992, as in effect on Sept. 1, 1992; changes in subparts H, R and preamble to the Feb. 28, 1992 final rule issued Aug. 11, 1992, as in effect on Sept. 1, 1992; technical corrections made in subparts T, F, A, K, C, Q, M and R issued Jan. 19, 1993, as in effect on Sept. 1, 1992; and changes in subparts M and K issued July 22, 1993, as in effect on Jan. 19, 1993.

(2) "Clinical consultant" means the individual or individuals in the laboratory defined by 42 CFR 493.1417(b), as in effect on Sept. 1, 1992 or 493.1455(b), as in effect on Sept. 1, 1992.

(b) The laboratory or laboratories performing analytical tests within the hospital shall hold a valid CLIA certificate for the type and complexity of all tests performed.

(c) Clinical laboratory services shall be available on the hospital premises or provided by a CLIA certified laboratory.

(d) An "authorized individual" shall, through written or electronic means, request all tests performed by the laboratory. The individual or individuals serving as the laboratory's clinical consultant or consultants, defined by 42 CFR 493.1417(b), as in effect on Sept. 1, 1992 or 493.1455(b), as in effect on Sept. 1, 1992, shall clearly define in writing an "authorized individual."

(e) All tissues removed shall be macroscopically examined. If deemed necessary, by written hospital policies and procedures, tissues shall then be microscopically examined. A list of all tissues which routinely do not require microscopic examination shall be developed in writing by a pathologist and approved by the medical staff of each hospital.

(f) The original report or duplicate copies of written tests reports and supporting records shall be retained in a readily retrievable form by the laboratory for a period of at least:

(1) two years for routine test reports;

(2) five years for blood banking test reports; and

(3) ten years for histologic or cytologic test reports.

(g) Facilities for procurement, safekeeping, and transfusion of blood, blood products or both shall be provided or readily available. If blood products or transfusion services are provided by sources outside the hospital, they shall be provided by a CLIA certified laboratory. The source shall be certified for the scope of testing performed or products provided.

(h) Laboratories shall release all proficiency test results to KDHE within seven days of a written request.

Authorized by and implementing K.S.A. 65-431; effective Jan. 1, 1969; amended Jan. 1, 1974; amended May 3, 1996.

28-34-12. Radiology department.

(a) Facilities for diagnostic radiology shall be available.

(b) Emergency radiological services shall be reasonably available at all times.

- (c) The radiology department and all patient services rendered therein shall be under the supervision of a designated medical staff physician; wherever possible, this physician shall be an attending or consulting radiologist.
- (d) The technical personnel working in the department shall be qualified for the type of service performed.
- (e) Written medical policies and procedures shall be developed under the direction of the physician responsible for the patient services of the department.
- (f) Rooms in which ionizing radiation producing devices or equipment or radioactive materials are to be used or stored shall afford radiation protection in accordance with the Kansas radiation protection regulations and the recommendations of the national council on radiation protection and measurements.
- (g) Radioactive materials and ionizing radiation producing devices and equipment shall be procured, stored, used, and disposed of in accordance with the Kansas radiation protection regulations and the license or registration required by the regulations as authorized by K.S.A. 48-1607.
- (h) All control devices, switches, and electrical connections for radiological equipment shall conform to the requirements of the national board of fire underwriters.
- (i) All X-ray and gamma beam therapy equipment shall be calibrated at least annually by a qualified expert according to definitions and procedures provided by the national council on radiation protection, as amended. All radiation producing equipment, therapeutic or diagnostic, shall be inspected at least every two years by the appropriate state agency. The designated radiation safety officer or physician in charge of the radiology department shall be furnished a signed copy of such inspection reports.
- (j) Therapeutic radiation shall be administered to patients only at the direction and under the supervision of a radiologist.
- (k) Diagnostic and therapeutic use of radioactive isotopes and radium therapy shall conform to applicable state and federal regulations, and shall be under the supervision of a radiologist or other qualified physician.
- (l) The interpretation of all radiological examinations shall be made by physicians.
- (m) A written report of the findings and evaluation of each radiological examination performed or course of treatment conducted shall be signed by the physician responsible for the procedure and shall be made a part of the patient's permanent medical record.
- (n) Personnel exposure monitoring shall be maintained for each person regularly working in the radiation area. Regular periodic recording of cumulative exposure shall be maintained for each person so monitored, and shall contain at least all of the information required by the Kansas radiation protection regulations for such records. Records shall be retained for the periods of time required by Kansas radiation protection regulations.
- (o) No person under 18 years of age shall be permitted to operate radiation producing equipment.
- (p) Fluoroscopy shall be conducted by or under the direct supervision of a physician.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-13. Central sterilizing and supply.

- (a) Policies and procedures shall be established in writing for storage, maintenance, and distribution of supplies and equipment.
- (b) Sterile supplies and equipment shall not be mixed with unsterile supplies, and shall be stored in dust-proof and moisture-free units. They shall be properly labeled.

(c) Sterilizers and autoclaves shall be provided of appropriate type and necessary capacity to adequately sterilize instruments, utensils, dressings, water, operating and delivery room materials, as well as laboratory equipment and supplies. The sterilizers shall have approved control and safety features. The accuracy of instruments shall be checked periodically by an approved method. Adequate surveillance methods for checking sterilization procedures shall be employed.

(d) The date of sterilization or date of expiration shall be marked on all sterile supplies, and unused items shall be resterilized in accordance with written policies.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-14. Dietary department.

(a) The dietary department shall be under the supervision of qualified personnel. A consultant dietitian may supervise the dietary department of a small hospital which does not employ a full-time qualified dietitian; a properly qualified food service supervisor may substitute if a qualified dietitian is not available.

(b) In the absence of a full-time dietitian or food service supervisor, there shall be a cook manager who is responsible for the daily management of the department.

(c) There shall be written policies for food storage, preparation, and service. Policies shall conform to good sanitation practices.

(d) The food and nutritional needs of patients shall be met in accordance with the recommended dietary allowance of the food and nutrition board of the national research council and in accordance with physician's orders.

(e) Regular menus and modifications for basic therapeutic diets shall be written at least one week in advance and posted in the kitchen.

(f) Adequate administrative, working, and storage space and facilities shall be provided. There shall be a separate storage area above floor level for food.

(g) There shall be a dining area appropriate to the needs of the hospital.

(h) Dumbwaiters or other transportation equipment shall not be used to transport simultaneously both clean and unclean dishes. Dumbwaiters and other transportation equipment shall be cleaned and disinfected daily.

(i) Equipment and facilities shall be adequate to allow storage, preparation, cooking, and serving of food and drink to patients, staff, and employees in a proper and sanitary manner. There shall be separate handwashing facilities in the food preparation and service area.

(j) Temperatures in food freezers shall be no higher than 0 [degree] Fahrenheit.

(k) Dishes and utensils shall be washed in water at 140 [degrees] Fahrenheit, and shall be rinsed at 180 [degrees] Fahrenheit.

(l) Food service personnel shall wear washable garments, hair nets covering all of the hair (for women), clean caps (for men), and shall keep hands and fingernails clean at all times.

(m) Foods being transported shall be protected from contamination and held at proper temperatures in clean containers or serving carts.

(n) All applicable codes and ordinances shall be met.

(o) Storage of toxic agents shall be prohibited in food preparation and food serving areas.

(p) Only grade "A" pasteurized milk shall be used. Milk and fluid milk products shall be served from the distributor's original containers or from a bulk container equipped with an approved dispensing device.

(q) All red meat and poultry shall be state or federally inspected and approved.

(r) Food returned on patient's trays shall not be reused.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-15. Laundry.

(a) The hospital shall make provisions for the proper laundering of linen and washable goods.

(b) When linen is laundered outside of the hospital, the hospital shall be responsible to assure that the requirements of these standards are covered in the terms of the contract or agreement.

(c) Hospital employees involved in transporting, processing, or otherwise handling clean or soiled linen shall be properly trained to ensure patient and employee safety.

(d) No laundry operations shall be carried out in patient care areas, nor in areas where food is prepared, served, or stored.

(e) All soiled linen shall be clearly identified.

(f) Soiled linen from infectious or isolation areas shall be bagged, marked, and laundered separately.

(g) Soiled diapers and nursery linen shall be washed separately.

(h) Soiled linen shall be sorted only in the sorting area.

(i) The washing and rinsing process shall be adequate to provide protection to patients and personnel. The temperature of water during the washing process shall be controlled to provide minimum temperature of 165 [degrees] Fahrenheit for 25 minutes.

(j) Personnel handling soiled linen shall wash their hands after completing work with soiled linen.

(k) The finished "clean" linen and other washable goods shall be transported to the storage area or nursing units in conveyances used exclusively for "clean" goods.

(l) Clean linen stored in storage areas or on nursing units shall be in closets, shelves, conveyances, or rooms used exclusively for this purpose.

(m) All clean linen being transported shall be protected from contamination.

(n) Adequate space and equipment shall be provided for the laundry operation of the hospital.

(o) Sanitation controls shall be maintained.

(p) Laundry chutes shall be used only for soiled linen that has been properly bagged.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-16a. Emergency services.

(a) Emergency services plans. Each hospital shall maintain a comprehensive, written emergency services plan based on community need and on the capability of the hospital. This plan shall include procedures whereby an ill or injured person can be addressed and either treated, referred to an appropriate facility or discharged. Regardless of the scope of its services, each hospital shall provide and maintain equipment necessary to institute essential life-saving measures for inpatients and, when referral is indicated, shall arrange for necessary transportation.

(b) Organized emergency services. In hospitals with organized emergency services, the following shall apply.

(1) Emergency services shall be available 24 hours a day, and medical staff coverage shall be adequate so that the patient will be seen within a period of time which is reasonable relative to the severity of the patient's illness or injury.

(2) No patient shall be transferred until the patient has been stabilized. A written statement of the patient's immediate medical problem shall accompany the patient when transferred. Every patient seeking medical care from the emergency services who is not in need of immediate medical care or for whom services cannot be provided by the hospital shall be given information about obtaining medical care.

(3) The emergency service, regardless of its scope, shall be organized and integrated with other departments of the hospital.

(4) The service shall be directed by a physician. The governing body shall adopt a written statement defining the qualifications, duties, and authority of the director. In the absence of a single physician, the direction of emergency medical services may be provided through a multidisciplinary medical staff committee, including at least one physician. The chairperson of this committee shall serve as director.

(5) The emergency nursing service shall be directed and supervised by a registered nurse with training in cardiopulmonary resuscitation. At least one registered nurse with this training shall be available at all times.

(6) The emergency service area shall be located near an outside entrance to the hospital and shall be easily accessible from within the hospital. Suction and oxygen equipment and cardiopulmonary resuscitation units shall be available and ready for use. This equipment shall include equipment used for tracheal intubation, tracheotomy, ventilating bronchoscopy, intra-pleural decompression and intravenous fluid administration. Standard drugs, parental fluids, plasma substitutes and surgical supplies shall be on hand for immediate use in treating life-threatening conditions.

(7) Written policies and procedures which delineate the proper administrative and medical procedures and methods to be followed in providing emergency care shall be established. A medical record shall be kept for each patient receiving emergency services and it shall be made a part of any other patient medical record maintained in accordance with K.A.R. 28-34-9a and amendments thereto.

(c) Cessation of organized emergency services. Any hospital ceasing to provide organized emergency services, at least 30 days prior to such action, or as soon as possible, shall:

(1) Document approval of the governing body of the closure of the organized emergency services;

(2) notify the licensing agency;

(3) place a legal public notice in the local newspaper of such cessation of services; and

(4) notify the Kansas department of transportation and the Kansas board of emergency medical services.

Authorized by and implementing K.S.A. 65-431; effective June 28, 1993.

28-34-17a. Anesthesia services.

(a) General provisions. Anesthesia care shall be regularly available when the hospital provides surgical or obstetrical services.

(b) Personnel.

(1) The department of anesthesia shall be responsible for all anesthetics administered.

(2) In hospitals where there is no department of anesthesia, the director of surgical services shall assume the responsibility for establishing general policies relating to administration of anesthetics. When there is a department of anesthesia, it shall be directed by a member of the medical staff with appropriate clinical and administrative experience.

(3) The responsibilities of the director shall be established by the governing body and shall include the following:

(A) Establishing criteria and procedures for the evaluation of the quality of all anesthesia care rendered in the hospital;

(B) making recommendations regarding necessary equipment for administering anesthesia and related resuscitation efforts;

(C) developing hospital rules concerning anesthesia safety; and

(D) participating in the hospital's program of cardiopulmonary resuscitation and in consultations regarding management of acute and chronic respiratory insufficiency.

(c) Anesthesia shall be provided only by a qualified individual licensed by the Kansas board of healing arts, the Kansas board of nursing, or the Kansas dental board to administer anesthesia. Anesthesia may also be administered by physicians who are residents in anesthesia or student nurse anesthetists under the supervision of an individual licensed to administer anesthesia.

(d) Policies.

(1) The governing body shall determine the extent of anesthesia services and shall define the degree of collaboration required for the administration of anesthesia. Certified registered nurse anesthetists shall work in an interdependent role with other practitioners.

(2) Each patient requiring anesthesia shall have a pre-anesthesia evaluation by a qualified anesthesia provider regarding the choice of anesthesia.

(3) Each patient's condition shall be reviewed immediately prior to induction. This shall include a review of the patient's medical record with regard to completeness of pertinent laboratory data and an appraisal of any changes in the condition of the patient as compared with that noted on the patient's medical record.

(4) Following the procedure for which anesthesia was administered, the anesthetist or a designee shall remain with the patient as long as required by the patient's condition relative to the patient's anesthesia status and until responsibility for proper patient care has been assumed by other qualified individuals.

(5) A record of events taking place during the induction and maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions, shall be made.

(e) Safety precautions. The governing body, through the director of anesthesia services, shall adopt rules for safe practice in anesthetizing locations. These rules shall be substantially similar to the requirements prescribed in

appendix B of NFPA No. 56A (1973), "standard for the use of inhalation anesthetics," as published by the national fire protection association, Boston, Massachusetts. Separate rules shall be adopted for hospitals having flammable anesthetizing locations, nonflammable anesthetizing locations or mixed flammable and nonflammable anesthetizing locations. Flammable anesthetizing agents shall include cyclopropane, divinyl ether, ethyl ether, fluroxene, ethyl chloride and ethylene.

Authorized by and implementing K.S.A. 65-431; effective June 28, 1993.

28-34-17b. Surgical services.

(a) General provisions. Surgical services shall be provided in a manner sufficient to meet the medical needs of the patients.

(b) Personnel.

(1) The director of surgical services shall be a qualified member of the medical staff with appropriate surgical and administrative experience.

(2) A roster of medical staff members, with a delineation of the surgical privileges granted to each, shall be maintained in the surgical suite and available to the surgical nurse supervisor.

(3) Surgical suite nursing services shall be under the direction and supervision of a registered nurse who is qualified by training and experience in operating room management and techniques. At least one registered nurse shall be on duty in the recovery room whenever the room is occupied.

(c) Facilities.

(1) Admission of patients, personnel and visitors to the surgical suite shall be controlled in accordance with written policies.

(2) The following equipment shall be immediately available to the surgical suite:

(A) A call system;

(B) a cardiac monitor;

(C) a resuscitator;

(D) a defibrillator;

(E) an aspirator;

(F) a thoracotomy set; and

(G) a tracheotomy set.

(3) Facilities for blood transfusions shall be available at all times.

(d) Policies. The medical staff shall develop written policies and procedures governing surgical services. These shall include:

(1) Appointment procedures which fairly evaluate the quality and competence of each surgeon seeking appointment to the surgical staff;

(2) reappointment procedures which provide for the periodic reappraisal of the qualifications and competence of each surgeon;

(3) criteria to determine the circumstances which require the presence of an assistant during surgery and to determine whether the assistant should be a physician or professional or nonprofessional personnel;

(4) procedures requiring that preoperative and postoperative medical records are completed in a timely and accurate manner. An accurate and complete description of findings and techniques of operation shall be made within 24 hours after operation by the surgeon who performed the operation; and

(5) procedures requiring that all tissues removed at surgery be examined by a physician whose report shall become a part of the patient's medical record.

(e) Operating room register. An operating room register shall be provided and maintained on a current basis. This register shall contain the date of the operation, the name and number of the patient, the names of surgeons and surgical assistants, the name of the anesthetist, the type of anesthesia given, preoperative and postoperative diagnosis, the type of surgical procedure and the presence or absence of complications in surgery.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-18a. Obstetrical and newborn services.

(a) General provisions. If the hospital provides obstetrical and newborn services, they shall be provided in a manner sufficient to meet the medical needs of the patients.

(b) Personnel.

(1) The director of the obstetrical services shall be a member of the medical staff who has experience in obstetrics. The director of the newborn nursery service shall be a member of the medical staff who has experience in pediatrics. The obstetrical and newborn nursing services, including labor, delivery, recovery, and postpartum care, shall be under the supervision of a registered professional nurse qualified by education and experience to provide nursing care to the obstetric and newborn patients.

(2) Personnel qualified to administer inhalation and regional anesthesia shall be readily available. A registered professional nurse shall be available to supervise staff who are monitoring labor, delivery, recovery, and postpartum patients. Labor, delivery, and recovery rooms, when occupied, shall have continuous coverage by nursing staff qualified by education and experience in intrapartum and postdelivery care. The newborn nursery shall be under the supervision of a registered professional nurse qualified by education and experience in the care of normal and high-risk infants.

(c) Facilities and equipment. The obstetrical and newborn services shall include facilities to provide for labor, delivery, recovery, postpartum, and newborn care in a designated area.

(1) Each labor room shall have access to the following:

(A) Toilet facilities;

(B) handwashing facilities in or immediately adjacent to each labor room;

(C) oxygen and suction equipment;

(D) a nurse call system;

(E) an emergency delivery pack;

- (F) resuscitation equipment;
- (G) a fetal monitor;
- (H) intravenous therapy solutions and equipment; and
- (I) emergency tray with drugs appropriate to obstetrical emergencies.

(2) Each delivery room shall have access to the following:

- (A) Equipment appropriate for maternal and newborn resuscitation, including suction, airways, endotracheal tubes, and ambubags;
- (B) equipment for administration of inhalation and regional anesthetics;
- (C) a functioning source of emergency electrical power;
- (D) an emergency call or intercommunication system;
- (E) oxygen and suction equipment which can be accurately regulated;
- (F) a fetal monitor;
- (G) supplies and instruments for emergency Cesarean section;
- (H) a scrub sink with foot, knee, or elbow control;
- (I) prophylactic solution approved by the licensing agency for instillation into eyes of newborn pursuant to K.S.A. 65-153 and K.A.R. 28-4-73 and any amendments thereto;
- (J) a method for identification of the newborn and mother;
- (K) a movable, heated bassinet, a bassinet with a radiant warmer, or a transport isolette for the newborn while in the delivery room and during transport from the delivery room; and
- (L) a sink with foot, knee, or elbow control.

(3) Each normal or neonatal intensive care nursery shall have access to the following:

- (A) A bassinet or isolette for the exclusive use of each infant and for storage of individualized equipment and supplies;
- (B) oxygen, oxygen analyser, and suction equipment which can be accurately regulated;
- (C) phototherapy light;
- (D) intravenous infusion solutions and equipment. A pump shall also be available;
- (E) sink with foot, knee, or elbow control; and
- (F) newborn resuscitation equipment.

(d) General requirements.

(1) When an infected patient is delivered in the delivery room, an established infection control protocol shall be followed. An operating room may be used for delivery when the delivery rooms are occupied and for Cesarean sections or obstetrical complications.

(2) Any room may be used as a birthing room when the hospital has a birthing room program that is approved by the licensing agency.

(3) Newborn services shall provide for newborn recovery, observation, and isolation, and for high-risk infants, access to care in a neonatal intensive care nursery either at the hospital of birth or by transfer to a hospital with a neonatal intensive care unit.

(4) All necessary supplies shall be stored in covered containers to permit individualized care.

(e) Procedures and policies. The directors of the obstetrical and newborn services, in cooperation with nursing service, shall develop procedures and policies which shall be available to the medical and nursing staff. Minimal procedures shall include the following:

(1) Oxygen shall be administered only with proper apparatus for its safe administration and control of concentration. Concentrations of oxygen shall not exceed a safe level commensurate with current concepts of oxygen therapy.

(2) Identification shall be attached to the mother and newborn infant before they are removed from the delivery room.

(3) Hospital infection control protocol shall be followed with each patient admitted to the labor and delivery, nursery, or postpartum areas with suspected or confirmed transmissible infection.

(4) Each newborn shall be transported to the mother's room or other units outside the nursery in an individual bassinet.

(5) Each infant shall be tested for phenylketonuria, congenital hypothyroidism, and galactosemia prior to being discharged.

(6) Additional policies shall be adopted concerning, at minimum, the following:

(A) The use of oxytocic drugs and the administration of anesthetics, sedatives, analgesics, and other drugs;

(B) the development of a current roster of physicians with a delineation of their obstetrical privileges. The roster shall be maintained and made available to personnel;

(C) the housing of gynecology patients on the maternity unit;

(D) the presence of fathers or other support persons in the labor, delivery, and birthing rooms;

(E) the protocol for visitors to labor and recovery patients and to the nursery and postpartum units;

(F) attire and handwashing protocols for obstetrical and newborn unit staff and other hospital staff entering these units;

(G) the flow of hospital staff between the obstetric and newborn units and other patient care areas;

(H) the procedure for obtaining blood samples for newborn screening lists, in compliance with K.S.A. 65-180 et seq. and any amendments to it, prior to newborn discharge;

(I) the procedure for reporting to the licensing agency within 48 hours when two or more infants in a nursery demonstrate simultaneous evidence of an infectious disease of a similar nature;

(J) an infection control program for labor, delivery, postpartum, and nursery area which shall include specific procedures for patient isolation and the cleaning, disinfection, and sterilization of patient areas, equipment, and supplies.

(K) arrangements for implementing patient education programs and family-centered care and for promoting parental/sibling/newborn attachment and initiation of breastfeeding;

(L) a system to facilitate coordination of prenatal and postpartum referral and follow up for mothers and newborns at risk and those being discharged less than 24 hours post delivery;

(M) a defined routine for care of obstetrical and newborn patients;

(f) Perinatal Committee. The hospital shall establish an obstetrical and newborn services committee to monitor, evaluate, and recommend the provision of patient services. The committee membership shall include appropriate medical and nursing staff personnel.

Authorized by and implementing K.S.A. 65-431; effective May 1, 1986.

28-34-19. Pediatric department. Hospitals with an organized pediatric department shall provide facilities for the care of children, apart from the services for adult patients and from the newborn nursery, and there shall be proper facilities and procedures for the isolation of children with infectious, contagious or communicable conditions.

(a) The pediatric department shall be under the supervision of a designated staff physician.

(b) Hospitals providing pediatric care shall be evaluated and approved on the basis of the size of the service, the personnel, facilities, policies, and procedures.

(c) The newborn nursery and the pediatric department shall not be used for boarding care of illegitimate, dependent, neglected, or defective children. If, at the end of the period for which progressive medical care is indicated, the hospital is unable to properly discharge such infants, their presence shall be reported to the division of maternal and child health of the state department of health for suitable action by said department.

(d) Policies shall be established to cover conditions under which parents may stay with small children or "room-in" with their hospitalized child for moral support and assistance with care.

(e) There shall be appropriate referrals to public health nurses or other agencies for followup care as needed.

(f) Adolescents shall be separated from younger children. Reasonable privacy, without limiting necessary observation, shall be available for adolescents.

Authorized by K.S.A. 65-431; effective Jan. 1, 1969.

28-34-20a. Outpatient and short-term procedure services.

(a) General provisions. If the hospital provides outpatient services, those services shall be rendered in an effective and timely manner and shall be given only on the order of a physician or practitioner.

(b) Outpatient services.

(1) The director of the outpatient service shall possess qualifications that are consistent with the criteria, authority and duties defined in a written statement adopted by the hospital. The service shall be staffed with sufficient qualified personnel to meet the needs of the patients.

(2) Each outpatient service facility in which patient medical care is delivered shall be designed to ensure the privacy of each patient and the confidentiality of the patient's disclosures. Consultation and examination rooms or cubicles appropriate to the size of the service shall be available for the use of the staff.

(c) Short-term procedure services.

(1) If the hospital maintains a short-term procedure unit for treating patients requiring surgery on an outpatient basis, the unit shall be established and administered according to procedures developed by the medical staff and adopted by the governing body. Provision shall be made for backup services by other departments in the case of emergencies or complications.

(2) The following basic facilities shall be provided when outpatient surgery is performed:

(A) An appropriately equipped and staffed operating room and postoperative recovery room;

(B) appropriate means of control against the hazards of infection, electrical or mechanical failure, fire or explosions;

(C) facilities for sterilizing equipment and supplies for maintaining sterile techniques;

(D) appropriate equipment and instrumentation for anesthesia, emergency cardiopulmonary resuscitation and other physiologic support;

(E) a readily available oxygen supply with emergency tanks; and

(F) readily available suction equipment.

The operating room shall be located so that it does not directly connect with a corridor used for general through traffic.

(d) Policies and procedures.

(1) Policies and procedures shall be developed to guide personnel in the effective implementation of the objectives of the outpatient services.

(2) Outpatient services shall be provided in accordance with established policies and procedures. In hospitals which do not provide an organized emergency service but provide outpatient services, outpatient services shall be provided during regularly scheduled hours. The hours of operation for the outpatient service shall be posted in the outpatient service waiting area.

Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.

28-34-22. Physical therapy department. In hospitals where organized departments of physical therapy are established the following shall apply:

(a) Physical therapy services shall be under the direction of a physician.

(b) At least one registered physical therapist shall be employed for the department. In hospitals where the day-to-day services are provided by a physical therapy assistant or other supportive personnel, a part-time or consulting physical therapist shall be utilized to provide general supervision of the department.

- (c) Other professional or supportive personnel shall be included as required to assure adequate patient care. All personnel shall be qualified by training or experience for the services they are rendering.
- (d) Policies for the physical therapy department shall be written and shall be reviewed and revised as necessary.
- (e) When a patient is referred to the physical therapy department, the treatment to be administered shall be recorded on the patient's chart, including all pertinent details of the treatment procedure.
- (f) Records of inpatients and outpatients treated in the physical therapy department shall be maintained. The date of each patient visit shall be recorded as well as modalities employed and the area or areas treated. Patient progress notes shall be maintained.
- (g) Facilities, space, and equipment required shall depend upon the physical therapy services provided, but shall be sufficient to assure adequate care. The equipment shall be maintained in proper working condition to assure adequate patient benefit.

Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1969; amended Jan. 1, 1974.

28-34-23. Inhalation or respiratory therapy department. In hospitals with an organized inhalation department, the following shall apply:

- (a) Inhalation or respiratory therapy services shall be under the guidance of a designated staff physician.
- (b) Equipment shall be appropriate for the services provided and shall be checked periodically by the hospital for performance.
- (c) The personnel working in the department shall be qualified for the type of services performed.
- (d) Supplies shall be kept and stored in a manner that promotes safety in the hospital.

Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-24. Social services department. In hospitals with an organized department of social services, the following shall apply:

- (a) The department shall be under the guidance of a qualified social worker.
- (b) Appropriate facilities and personnel shall be provided in accordance with the hospital's program.
- (c) Records shall be kept of the social services provided.

Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-25. Occupational therapy department. In hospitals with an organized occupational therapy department, the following shall apply:

- (a) The department shall be under the guidance of a qualified occupational therapist.
- (b) Facilities and personnel shall be provided commensurate with the hospital's program.
- (c) Records shall be kept on the services provided.

Authorized by K.S.A. 65-431; effective Jan. 1, 1974.

28-34-29a. Long-term care unit.

(a) General provisions. If the hospital provides a long-term care service, such service shall be provided in a manner that meets the medical, rehabilitative, and social needs of the patient.

(b) Scope of services.

(1) The long-term service shall have a written program of restorative nursing care. This program shall be an integral part of nursing services and shall be directed toward assisting the patient to achieve and maintain an optimum level of self-care and independence.

(2) In addition to restorative services, the unit shall provide or arrange for specialized rehabilitation services by qualified personnel as needed by patients to improve and maintain functioning. Services shall include physical therapy, speech pathology, audiology, and occupational therapy and shall be provided by qualified personnel.

(3) A written, overall care plan shall be developed for each long-term care patient from an interdisciplinary assessment of the patient. The interdisciplinary assessment shall consist of medical, nursing, dietary, activities, and psychosocial diagnoses or evaluations.

(c) Medical direction. A member of the medical staff shall be assigned responsibility for the medical direction of the service. The director shall be responsible for the overall coordination of medical care in the unit and shall participate in the development of policies and procedures for patient care, including the delineation of responsibilities of attending physicians.

(d) Nursing services.

(1) The nursing services director shall have the overall responsibility of providing nursing services. The immediate supervisor of nursing personnel assigned to long-term care services shall be a registered nurse employed on the day shift and whose responsibilities shall be limited to the long-term care unit. Licensed nursing personnel shall be in the building at all times to be available as needed to provide services in the long-term care unit.

(2) Nursing personnel shall be assigned duties consistent with their education and experience. Each nurse aide shall be trained and examined in accordance with K.A.R. 28-39-79 and K.A.R. 28-39-80. Each nurse aide trainee who provides direct, individual care to patients shall be under the direct, onsite supervision of a licensed nurse. Each nurse aide trainee shall complete requirements for and obtain certification as a nurse aide within six months of employment.

(3) Each patient shall receive direct, individual patient care at a minimum weekly average of 2.0 hours per 24 hours, and a daily average of not fewer than 1.85 hours during any 24-hour period. Only care provided by personnel exclusively assigned to the long-term care service, including nursing personnel, the activities director, and the social services designee, shall be considered in meeting the care requirements.

(e) Restraints. A signed physician's order shall be required for any restraint. The order shall include justification, type of restraint, and duration of application. A patient shall not be restrained unless, in the written opinion of the attending physician, restraints are required to prevent injury to the patient or to others.

(f) Patient care and hygiene. The long-term care service shall provide supportive services to maintain the patients' comfort and hygiene as follows:

(1) Patients confined to bed shall receive a complete bath every other day or more often as needed.

(2) Incontinent patients shall be checked at least every two hours and shall be given partial baths and clean linens promptly when the bed or clothing is soiled.

(3) Pads shall be used to keep the patients dry and comfortable.

(4) Rubber, plastic, or other types of protectors shall be kept clean, completely covered, and not in direct contact with the patients.

(5) Soiled linen and clothing shall be removed immediately from the patients' rooms to prevent odors.

(6) Fresh water shall be available for each patient. For each non-ambulatory patient, fresh water or other fluids shall be available at the bedside at all times unless fluids are restricted by physician's order.

(7) Each patient shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be taken to prevent dry, cracked lips.

(8) A written, ongoing program for skin care shall be implemented as follows:

(A) Bony prominences and weight-bearing parts, such as heels, elbows, and back, shall be bathed and given care frequently to prevent discomfort and the development of pressure sores.

(B) Treatment for pressure sores shall be given according to written physician's orders.

(C) The position of each patient confined to bed shall be changed at least every two hours during the day and night.

(D) Each patient shall be positioned in good body alignment.

(E) Precautions shall be taken to prevent foot drop in bed patients.

(g) Restorative nursing care. Each nursing personnel shall receive regular staff development training sessions in restorative techniques. Documentation of such training shall be maintained.

(h) Specialized rehabilitative services.

(1) Rehabilitation needs shall be met either through services provided directly by the hospital or through arrangements with qualified outside resources.

(2) Commensurate with the services offered, adequate space and equipment shall be available.

(3) Each rehabilitative service performed shall be recorded in the patient's record and shall be signed and dated by the person providing the service.

(4) Written policies and procedures shall be developed for specialized rehabilitative services with input from qualified therapists and representatives of the medical, administrative, and nursing staffs.

(5) A written plan of care, initiated by the attending physician and developed in consultation with the therapist or therapists involved and with nursing services, shall be developed for each patient receiving rehabilitative services. A report of the patient's progress shall be communicated to the attending physician within two weeks of the initiation of the service. Thereafter, the patient's progress shall be reviewed and revised on not less than a quarterly basis.

(i) Social services. The long-term care service shall have methods for identifying the medically-related, psychosocial needs of each patient. Needs shall be met by qualified staff of the hospital or by referral to an outside resource through established procedures.

Authorized by and implementing K.S.A. 65-431; effective May 1, 1986.

28-34-31. General sanitation and housekeeping.

- (a) Hospitals shall comply with applicable codes.
- (b) Suitable equipment shall be provided for the regular cleaning of all interior surfaces. Operating and delivery rooms shall be thoroughly cleaned after each operation or delivery. Patient rooms shall be thoroughly cleaned after discharge. No wax shall be applied to conductive floors which will render them nonconductive. Adequate and conveniently located spaces shall be provided for the storage of janitorial supplies and equipment.
- (c) The premises shall be kept neat, clean, and free of rubbish.
- (d) Housekeeping procedures shall be written.
- (e) All garbage and waste shall be collected, stored, and disposed of in a manner that will not encourage the transmission of contagious disease. Containers shall be washed and sanitized before being returned to work areas or shall be disposable.
- (f) All openings to the outer air shall be effectively protected against the entrance of insects and other animals by self-closing doors, closed windows, screening, controlled air currents, or other effective means. Screening material shall not be less than 16 mesh to the inch or equivalent.
- (g) A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after every handwashing. Common towels are prohibited.
- (h) There shall be adequate handwashing facilities conveniently located.
- (i) Common drinking cups shall be prohibited.
- (j) Dry sweeping and dusting shall be prohibited. Use of a rotary buffer shall be prohibited in areas such as isolation to aid in reducing the spread of pathogenic bacteria.
- (k) Adequate and conveniently located toilet facilities shall be provided.
- (l) Periodic checks shall be made throughout the buildings and premises to enforce sanitation procedures. The times and results of such checks shall be recorded.

Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-32b. Construction standards.

- (a) General provisions. All hospital construction, including new buildings and additions or alterations to existing buildings, shall be in accordance with the standards set forth in the American institute of architects academy of architecture for health, publication no. ISBN 1-55835-151-5, entitled "1996-97 guidelines for design and construction of hospital and health care facilities," copyrighted in 1996, and hereby adopted by reference.
- (b) Construction plans and specifications.
 - (1) Plans and specifications for each new hospital and each alteration and addition to any existing hospital, other than minor alterations, shall be prepared by an architect licensed in Kansas. "Minor alterations" means those projects that meet the following conditions:

- (A) Do not affect the structural integrity of the building;

- (B) do not change functional operation;
- (C) do not affect fire safety; and
- (D) do not add beds or facilities over those for which the hospital is licensed.

(2) The preliminary plan, plans and specifications at the outline specification stage, and plans and specifications at the contract document stage shall be made available to the licensing agency upon request.

(3) The preliminary plans shall include the following:

- (A) Sketch plans of the basement, each floor, and the roof, indicating the space assignment, size, and outline of fixed equipment;
- (B) all elevations and typical sections;
- (C) a plot plan showing roads and parking facilities; and
- (D) areas and bed capacities by floors.

(4) The outline specifications shall consist of a general description of the construction, air conditioning, heating, and ventilation systems.

(5) Contract documents shall consist of working drawings that are complete and adequate for bidding, contract, and construction purposes. Specifications shall supplement the drawings to fully describe the types, sizes, capacities, workmanship, finishes, and other characteristics of all materials and equipment. Before commencing construction, the architect shall certify, in writing, to the agency that the contract documents are in compliance with subsections (a), (b), and (c) of this regulation. The written certification shall also include the following:

- (A) The name of the facility;
- (B) a narrative description of extent of the project;
- (C) the physical location of the project;
- (D) any change in room numbers and bed assignments; and
- (E) the expected completion date of the project to the licensing agency, which shall be provided at least 30 days before the project completion date.

(c) The administrator of the facility shall notify the state fire marshal's office of all hospital construction, alterations, or additions at the preliminary planning stage.

(d) Access. Representatives of the licensing agency shall, at all reasonable times, have access to work in preparation or progress, and the contractor shall provide proper facilities for the access and inspection. A complete set of plans and specifications shall be available on the job site for use by licensing agency personnel.

Authorized by and implementing K.S.A. 65-431; effective June 28, 1993; amended Feb. 9, 2001.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 52. MEDICAL CARE FACILITIES**

28-52-1. General requirements.

- (a) Each medical care facility shall establish a written plan for risk management and patient care quality assessment on a facility-wide basis.
- (b) The plan shall be approved and reviewed annually by the facility's governing body.
- (c) Findings, conclusions, recommendations, actions taken, and results of actions taken shall be documented and reported through procedures established within the risk management plan.
- (d) All patient services including those services provided by outside contractors or consultants shall be periodically reviewed and evaluated in accordance with the plan.
- (e) Plan format. Each submitted plan shall include the following:
 - (1) Section I--a description of the system implemented by the facility for investigation and analysis of the frequency and causes of reportable incidents within the facility;
 - (2) Section II--a description of the measures used by the facility to minimize the occurrence of reportable incidents and the resulting injuries within the facility;
 - (3) Section III--a description of the facility's implementation of a reporting system based upon the duty of all health care providers staffing the facility and all agents and employees of the facility directly involved in the delivery of health care services to report reportable incidents to the chief of the medical staff, chief administrative officer, or risk manager of the facility;
 - (4) Section IV, organization--a description of the organizational elements of the plan including:
 - (A) Name and address of the facility;
 - (B) name and title of the facility's risk manager;
 - (C) description of involvement and organizational structure of medical staff as related to risk management program, including names and titles of medical staff members involved in investigation and review of reportable incidents;
 - (D) organizational chart indicating position of the facility's review committee as defined in K.S.A. 65-4923 and L. 1986, Ch. 229, New Section 4(a)(2); and
 - (E) mechanism for ensuring quarterly reporting of incident reports to proper licensing agency.
 - (5) Section V--a description of the facility's resources allocated to implement the plan; and
 - (6) Section VI--documentation that the plan as submitted has been approved by the facility's governing body.
- (f) Plan submittal. On and after November 1, 1986, each medical care facility shall submit the plan to the department at least 60 days prior to the license renewal date. After an initial plan is approved, any amendments to the plan shall be submitted to the department.
- (g) Departmental review. Upon review of the facility's risk management plan or any amendments the department shall notify the facility in writing if the plan of amendments have been approved or disapproved. The written notification will specify the reason for disapproval.

(h) Revised plan. Within 60 days of the date the facility receives notification the plan has been disapproved, the facility shall submit a revised plan to the department.

(i) Plan publication. The plan shall be disseminated to personnel in accordance with the plan.

Authorized by and implementing L. 1986, Chapter 229, Sec. 3; effective, T-87-50, Dec. 19, 1986; effective May 1, 1987.

28-52-2. Incident reporting.

(a) Each medical care facility shall identify a written form on which employees and health care providers shall report clinical care concerns to the risk manager, chief of staff, or administrator. The original or complete copy of the incident report shall be sent directly to the risk manager, chief of staff, or administrator, as authorized in the facility's risk management plan.

(b) The risk manager, chief of staff, or administrator shall acknowledge the receipt of each incident report in writing. This acknowledgment may be made in the following manner:

- (1) file stamping each report;
- (2) maintaining a chronological risk management reporting log;
- (3) signing or initialing each report in a consistent fashion; or
- (4) entering pertinent information into a computer database.

(c) Incident reports, investigational tools, minutes of risk management committees, and other documentation of clinical analysis for each reported incident shall be maintained by the facility for not less than one year following completion of the investigation.

Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.

28-52-3. Risk management committee.

(a) Each medical care facility shall designate one or more executive committees responsible for making and documenting standard-of-care determinations with respect to each incident report, pursuant to K.A.R. 28-52-2. The jurisdiction of each risk management committee shall be clearly delineated in the facility's risk management plan, as approved by the facility's governing body.

(b) The activities of each risk management committee shall be documented in its minutes at least quarterly, and this documentation shall demonstrate that the committee is exercising overall responsibility for standard-of-care determinations delegated by the committee to individual clinical reviewers and subordinate committees.

Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.

28-52-4. Standard-of-care determinations.

(a) Each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form:

- (1) Standards of care met;

- (2) standards of care not met, but with no reasonable probability of causing injury;
- (3) standards of care not met, with injury occurring or reasonably probable; or
- (4) possible grounds for disciplinary action by the appropriate licensing agency.

(b) Each reported incident shall be assigned an appropriate standard-of-care determination under the jurisdiction of a designated risk management committee. Separate standard-of-care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts. Any incident determined by the designated risk management committee to meet category (a)(3) or (a)(4) shall be considered a "reportable incident" and reported to the appropriate licensing agency in accordance with K.S.A. 65-4923.

(c) Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee. In those cases in which documented primary review by individual clinicians or subordinate committees does not occur, standard-of-care determinations shall be documented in the minutes of the designated committee on a case-specific basis. Standard-of-care determinations made by individual clinicians and subordinate committees shall be approved by the designated risk management committee on at least a statistical basis.

Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.

**AGENCY 28 DEPARTMENT OF HEALTH AND ENVIRONMENT
ARTICLE 70. CANCER REGISTRY**

28-70-1. Definitions.

(a) "Health care institution" means any of the following:

- (1) A hospital;
- (2) an outpatient surgery center;
- (3) a pathology laboratory; or
- (4) a radiation oncology center.

(b) "Individual provider" means a person licensed to practice medicine or surgery or a person licensed to practice dentistry.

(c) "Registry" means the cancer registry of the state of Kansas, as established by L. 1997, Ch. 110, Sec. 2 (a).

Authorized by and implementing L. 1997, Ch. 110, Sec. 2; effective Feb. 27, 1998.

28-70-2. Reporting requirements.

(a) Each health care institution shall, within six months of the date of diagnosis, report to the registry each case of cancer diagnosed or treated, unless exempted under subsection (c) of this regulation.

- (1) Each report shall provide all required information available in the medical records that are under the direct control of the reporting health care institution. A health care institution shall not be required to contact the patient, the patient's family, an individual provider, or another health care institution to obtain additional information not contained in the medical record.

(2) Any health care institution that has medical records of a cancer patient, but has not diagnosed or treated the cancer, shall provide information regarding that patient upon receipt of a written request from the registry.

(3) Each health care institution shall provide annual follow-up information regarding the outcome and status of each patient receiving cancer diagnostic or therapeutic services, upon receipt of a written request from the registry.

(4) Any pathology laboratory may submit a pathological report of each cancer to fulfill the laboratory's reporting requirement.

(b) Upon receipt of a request for information from the registry regarding a patient, each individual provider shall provide the requested information that is contained in medical records under the direct control of the provider.

(1) An individual provider shall not be required to report cancer cases, unless it receives a request for information from the registry regarding a specific patient.

(2) An individual provider shall not be required to contact the patient, the patient's family, a health care institution, or another individual provider to obtain additional information not contained in the medical record that is in the direct control of the provider.

(3) Each individual provider shall fulfill reporting requirements by completing any one of the following actions:

(A) Reporting to the registry the name of the hospital, outpatient surgery center, or radiation oncology center where the patient received cancer-related care;

(B) submitting, to the registry, copies of outpatient records, including surgical reports, cancer diagnostic reports, tumor histologic reports, and patient identification forms; or

(C) submitting a short form, supplied by the registry, that requests demographics, tumor histology and staging, patient identifiers, and names of treating institutions.

(c) Reports are not required for the following cancers:

(1) Squamous cell carcinoma of the skin, unless located on a lip of the face or in the genital area, or unless spread beyond local tissues at diagnosis;

(2) basal cell carcinoma of the skin, unless located on a lip of the face or in the genital areas, or unless spread beyond local tissues at diagnosis; and

(3) carcinoma in situ of the uterine cervix.

(d) Reports from health care institutions shall include the following information, if available:

(1) Patient demographics;

(2) diagnostic results and treatment;

(3) outcome, recurrence, and date of death, if applicable;

(4) cancer site, histology, and stage;

(5) confidential patient identifiers, including the following:

(A) Full name:

- (B) alias;
- (C) maiden name;
- (D) name of spouse;
- (E) medical record number;
- (F) social security number;
- (G) street address at the time of diagnosis;
- (H) current street address; and
- (I) current telephone number;

(6) confidential provider information, including names and address of health care institutions and individual providers of health care;

(7) history of abortion; and

(8) other variables identified as necessary by the registry director and approved by the secretary.

(e) Reports to the registry shall be in one of the following formats:

(1) American standard code for information interchange (ASCII) file in the North American association of central cancer registries (NAACCR) format;

(2) paper forms provided by the registry;

(3) a copy of the pathology laboratory report, if received from a pathology laboratory; or

(4) other formats identified as acceptable by the registry director.

(f) Any data transferred to the registry shall be secure and confidential.

(1) All paper data transferred to the registry shall be sealed in an envelope marked "CONFIDENTIAL" and addressed to the registry director.

(2) Electronic data transfer may be made by one of the following methods:

(A) Diskette mailed in a sealed envelope marked "CONFIDENTIAL" and addressed to the registry director; or

(B) electronic transmission, if encrypted, according to prior instructions from the registry director.

Authorized by and implementing L. 1997, Ch. 110, Sec. 2; effective Feb. 27, 1998.

28-70-3. Use and access.

(a) For purposes of ascertaining accuracy and completeness of cancer data, a person representing the registry may review the medical diagnosis of each person cared for by any individual provider or any health care institution, and may review the medical records of any person with cancer. Review shall be by prearrangement with the individual provider or health care institution.

(b) Any person who requests access to confidential registry data shall submit the request to a review panel, as established by L. 1997, ch. 110, Sec. 6, and amendments thereto. When the requestor demonstrates to the satisfaction of the review panel that the request complies with one or more of the conditions as defined in L. 1997, Ch. 110, Sec. 5, subsections (c) to (f), and amendments thereto, confidential data may be released by the panel.

Authorized by L. 1997, ch. 110, Sec. 2; implementing L. 1997, Ch. 110, Sec. 4 and Sec. 5; effective Feb. 27, 1998.

AGENCY 30 DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ARTICLE 5. PROVIDER PARTICIPATION, SCOPE OF SERVICES, AND REIMBURSEMENTS FOR
THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

30-5-58. Definitions. The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(a) "Accept medicare assignment" means the provider will accept the medicare-allowed payment rate as payment in full for services provided to a recipient.

(b) "Accrual basis accounting" means that revenue of the provider is reported in the period in which it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(c) "Acquisition cost" means the allowable reimbursement price for each covered drug, supply, or device as determined by the secretary in accordance with federal regulations.

(d) "Admission" means entry into a hospital for the purpose of receiving inpatient medical treatment.

(e) "Agency" means the department of social and rehabilitation services.

(f) "Ambulance" means a state-licensed vehicle equipped for emergency transportation of injured or sick recipients to facilities where medical services are rendered.

(g) "Arm's-length transaction" means a transaction between unrelated parties.

(h) "Border cities" means those communities outside of the state of Kansas but within a 50-mile range of the state border.

(i) "Capitated managed care" means a type of managed care plan that uses a risk-sharing reimbursement method whereby providers receive fixed periodic payments for health services rendered to plan members. Capitated fees shall be set by contract with providers and shall be paid on a per person basis regardless of the amount of services rendered or costs incurred.

(j) "Capitation reimbursement" means a reimbursement methodology establishing payment rates, per program consumer or eligible individual, for a designated group of services.

(k) "Case conference" means a scheduled, face-to-face meeting involving two or more persons to discuss problems associated with the treatment of the facility's patient or patients. Persons involved in the case conference may include treatment staff, or other department representatives of the client or clients.

(l) "Change of ownership" means a change that involves the following:

(1) An arm's-length transaction between unrelated parties; and

(2) (A) The dissolution or creation of a partnership when no member of the dissolved partnership or the new partnership retains ownership interest from the previous ownership affiliation;

(B) a transfer of title and property to another party if the property is owned by a sole proprietor;

(C) the change or creation of a new lessee acting as a provider of pharmacy services; or

(D) a consolidation of two or more corporations that creates a new corporate entity. The transfer of participating provider corporate stock shall not in itself constitute a change of ownership. A merger of one or more corporations with a participating provider corporation surviving shall not constitute a change of ownership.

(m) "Common control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(n) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility and in the company engaged in business with the provider facility.

(o) "Comparable outpatient service" means a service that is provided in a hospital and that is comparable to a service provided in a physician's office or ambulatory surgical center.

(p) "Concurrent care" means services rendered simultaneously by two or more eligible providers.

(q) "Consultation" means an evaluation that requires another examination by a provider of the same profession, a study of records, and a discussion of the case with the physician primarily responsible for the patient's care.

(r) "Contract loss" means the excess of contract cost over contract income.

(s) "Cost and other accounting information" means adequate data, including source documentation, that is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, financial and statistical records shall be maintained in a consistent manner. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedure.

(t) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(u) "Cost outlier" means a general hospital inpatient stay with an estimated cost that exceeds the cost outlier limit established for the respective diagnosis-related group.

(v) "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established according to a methodology specified by the secretary for each diagnosis-related group.

(w) "Cost-related reimbursement" means reimbursement based on analysis and consideration of the historical operating costs required to provide specified services.

(x) "Costs not related to patient care" means costs that are not appropriate, necessary, or proper in developing and maintaining the facility's operations and activities. These costs shall not be allowed in computing reimbursable costs under cost-related reimbursement.

(y) "Costs related to patient care" means all necessary and proper costs arising from arm's-length transactions in accordance with generally accepted accounting principles that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

(z) "Covered service" means a medical service for which reimbursement will be made by the medicaid/medikan program. Coverage may be limited by the secretary through prior authorization requirements.

(aa) "Day outlier" means a general hospital inpatient length of stay that exceeds the day outlier limit established for the respective diagnosis-related group.

(bb) "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the secretary for each diagnosis-related group.

(cc) "Diagnosis-related group" or "DRG" means the classification system that arranges medical diagnoses into mutually exclusive groups.

(dd) "Diagnosis-related group adjustment percent" or "DRG adjustment percent" means a percentage assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement.

(ee) "Diagnosis-related group daily rate" or "DRG daily rate" means the dollar amount assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement when a rate per day is required.

(ff) "Diagnosis-related group reimbursement system" or "DRG reimbursement system" means a reimbursement system in the Kansas medicaid/medikan program for general hospital inpatient services that uses diagnosis-related groups for determining reimbursement on a prospective basis.

(gg) "Diagnosis-related group weight" or "DRG weight" means the numeric value assigned to a diagnosis-related group for purposes of computing reimbursement.

(hh) "Discharge" means release from a hospital. A discharge shall occur when the consumer leaves the hospital or dies. A transfer to another unit within a hospital, except to a swing bed, and a transfer to another hospital shall not be a discharge.

(ii) "Discharging hospital" means, in instances of the transfer of a consumer, the hospital that discharges the consumer admitted from the last transferring hospital.

(jj) "Dispensing fee" means the reimbursement rate assigned to each individual pharmacy provider for the provision of pharmacy services involved in dispensing a prescription.

(kk) "Disproportionate share hospital" means a hospital that has the following:

(1) Either a low-income utilization rate exceeding 25 percent or a medicaid/medikan hospital inpatient utilization rate of at least one standard deviation above the mean medicaid/medikan inpatient utilization rate for hospitals within the state borders of Kansas that are receiving medicaid/medikan payments; and

(2) at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to medicaid/medikan eligible individuals. In a hospital located in a rural area, the obstetrician may be any physician with staff privileges at the hospital who performs nonemergency obstetric procedures. The only exceptions to this requirement shall be the following:

(A) A hospital with inpatients who are predominantly under 18 years of age; or

(B) a hospital that did not offer nonemergency obstetric services as of December 21, 1987.

(ll) "Drug, supply, or device" means the following:

(1) Any article recognized in the official United States pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications;

(2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings;

(3) any article intended to affect the structure or any function of the bodies of human beings; and

(4) any article intended for use as a component of any article specified in paragraphs (1), (2), or (3) above.

(mm) "Durable medical equipment" or "DME" means equipment that meets these conditions:

(1) Withstands repeated use;

(2) is not generally useful to a person in the absence of an illness or injury;

(3) is primarily and customarily used to serve a medical purpose;

(4) is appropriate for use in the home; and

(5) is rented or purchased as determined by designees of the secretary.

(nn) "Election period" means the period of time for the receipt of hospice care, beginning with the first day of hospice care as provided in the election statement and continuing through any subsequent days.

(oo) "Election statement" means the revokable statement signed by a consumer that is filed with a particular hospice and that consists of the following:

(1) Identification of the hospice selected to provide care;

(2) acknowledgment that the consumer has been given a full explanation of hospice care;

(3) acknowledgment by the consumer that other medicaid services are waived;

(4) the effective date of the election period; and

(5) the consumer's signature or the signature of the consumer's legal representative.

(pp) "Emergency services" means those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Serious jeopardy to the patient's health;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(qq) "Estimated cost" means the cost of general hospital inpatient services provided to a consumer, as computed using a methodology set out in the Kansas medicaid state plan.

(rr) "Formulary" means a listing of drugs, supplies, or devices.

(ss) "Free-standing inpatient psychiatric facility" means an inpatient psychiatric facility licensed to provide services only to the mentally ill.

(tt) "General hospital" means an establishment that provides an organized medical staff of physicians, permanent facilities that include inpatient beds, and medical services. The medical services provided by the hospital shall include the following:

- (1) Physician services;
- (2) continuous registered professional nursing services for 24 hours each day; and
- (3) diagnosis and treatment for nonrelated patients who have a variety of medical conditions.

(uu) "General hospital group" means the category to which a general hospital is assigned for purposes of computing reimbursement.

(vv) "General hospital inpatient beds" means the number of beds reported by a general hospital on the hospital and hospital health care complex cost report form, excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form, the number of beds shall be obtained from the provider application for participation in the Kansas medicaid/medikan program form.

(ww) "Generally accepted accounting procedures" means generally accepted accounting principles, except as otherwise specifically indicated by medicaid/medikan program policies and regulations. These principles shall not supersede any specific regulation or policy of the medicaid/medikan program.

(xx) "Group reimbursement rate" means the dollar value assigned by the secretary to each general hospital group for a diagnosis-related group weight of one.

(yy) "Health maintenance organization" means an organization of providers of designated medical services that makes available and provides these medical services to eligible enrolled individuals for a fixed periodic payment determined in advance and that limits referral to outside specialists.

(zz) "Historical cost" means actual allowable costs incurred for a specified period of time.

(aaa) "Hospice" means a public agency, private organization, or a subdivision of either, that primarily engages in providing care to terminally ill individuals, meets the medicare conditions of participation for hospices, and has enrolled to provide hospice services as provided in K.A.R. 30-5-59.

(bbb) "Hospital located in a rural area" means a facility located in an area outside of a metropolitan statistical area as defined in paragraph (sss).

(ccc) "Independent laboratory" means a laboratory that performs laboratory tests ordered by a physician and that is in a location other than the physician's office or a hospital.

(ddd) "Ineligible provider" means a provider who is not enrolled in the medicaid/medikan program because of reasons set forth in K.A.R. 30-5-60, or because of commission of civil or criminal fraud in another state or another program.

(eee) "Interest expense" means the cost incurred for the use of borrowed funds on a loan made for a purpose related to patient care.

(fff) "Kan Be Healthy program participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule. The medical screening shall be performed for the following purposes:

(1) To ascertain physical and mental defects; and

(2) to provide treatment that corrects or ameliorates defects and chronic conditions that are found.

(ggg) "Kan Be Healthy dental-only participant" means an individual under the age of 21 who is eligible for medicaid, and has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule. The dental screening shall be performed for the following purposes:

(1) To ascertain dental defects; and

(2) to provide treatment that corrects or ameliorates dental defects and chronic dental conditions that are found.

(hhh) "Kan Be Healthy vision-only participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule. The vision screening shall be performed for the following purposes:

(1) Ascertain vision defects; and

(2) provide treatment that corrects or ameliorates vision defects and chronic vision conditions that are found.

(iii) "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

(jjj) "Lock-in" means the restriction, through limitation of the use of the medical identification card to designated medical providers, of a consumer's access to medical services because of abuse.

(kkk) "Low-income utilization rate for hospitals" means the rate that is defined in accordance with section 1923 of the social security act, codified at 42 U.S.C. 1396r-4, as amended by section 1(a)(6) of the consolidated appropriations act, 2001 P.L. 106-554, which enacted into law Section 701 of H.R. 5661, the medicare, medicaid, and SCHIP benefits improvement and protection act of 2000, effective December 21, 2000, which is adopted by reference.

(lll) "Managed care" means a system of managing and financing health care delivery to ensure that services provided to managed care plan members are necessary, efficiently provided, and appropriately priced.

(mmm) "Managerial capacity" means the authority of an individual, including a general manager, business manager, administrator or director, who performs the following functions:

(1) Exercises operational or managerial control over the provider; or

(2) directly or indirectly conducts the day-to-day operations of the provider.

(nnn) "Maternity center" means a facility licensed as a maternity hospital that provides delivery services for normal, uncomplicated pregnancies.

(ooo) (1) "Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

(B) "Purpose." The health intervention has the purpose of treating a medical condition.

(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3). For existing interventions, effectiveness shall be determined as provided in paragraph (ooo)(4).

(E) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection (ooo);

(A) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(l) "Treating physician" means a physician who has personally evaluated the patient.

(3) Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph (ooo)(4).

(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

(ppp) "Medical necessity in psychiatric situations" means that there is medical documentation that indicates either of the following:

- (1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or
- (2) the person is disoriented in time, place, or person.

(qqq) "Medical supplies" means items that meet these conditions:

- (1) Are not generally useful to a person in the absence of illness or injury;
- (2) are prescribed by a physician; and
- (3) are used in the home and certain institutional settings.

(rrr) "Mental retardation" means any significant limitation in present functioning that meets these requirements:

- (1) Is manifested during the period of birth to age 18;
- (2) is characterized by significantly subaverage intellectual functioning as reflected by a score of two or more standard deviations below the mean, as measured by a generally accepted, standardized, individual measure of general intellectual functioning; and
- (3) exists concurrently with deficits in adaptive behavior, including related limitations in two or more of the following areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

(sss) "Metropolitan statistical area" or "MSA" means a geographic area designated as such by the United States executive office of management and budget as set out in the 64 Fed. Reg. 202, pp. 56628-56644, October 20, 1999, and 65 Fed. Reg. 249, pp. 82228-82238, December 27, 2000 which are adopted by reference.

(ttt) "Necessary interest" means interest expense incurred on a loan made to satisfy a financial need of the facility. A loan that results in excess funds or investments shall not be considered necessary.

(uuu) "Net cost" means the cost of approved educational activities, less any reimbursements from the following:

- (1) Grants;
- (2) tuition; and
- (3) specific donations.

(vvv) "Non-covered services" means services for which medicaid/medikan will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

(www) "Occupational therapy" means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall meet these requirements:

- (1) Be rehabilitative and restorative in nature;
- (2) be provided following physical debilitation due to acute physical trauma or physical illness; and
- (3) be prescribed by the attending physician.

(xxx) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of business. These costs shall be considered intangible assets because they represent expenditures for rights and privileges that have value to the enterprise. Because the services inherent in organization extend over more than one accounting period, the costs shall be amortized over a period of not less than 60 months from the date of incorporation for the purposes of computing reimbursable costs under a cost-related reimbursement system.

(yyy) "Orthotics and prosthetics" means devices that meet these requirements:

- (1) Are reasonable and necessary for treatment of an illness or injury;
- (2) are prescribed by a physician;
- (3) are necessary to replace or improve functioning of a body part; and
- (4) are provided by a trained orthotist or prosthetist.

(zzz) "Other developmental disability" means a condition or illness that meets the following criteria:

- (1) Is manifested before age 22;
- (2) may reasonably be expected to continue indefinitely;
- (3) results in substantial limitations in any three or more of the following areas of life functioning:
 - (A) Self-care;
 - (B) understanding and the use of language;
 - (C) learning and adapting;
 - (D) mobility;
 - (E) self-direction in setting goals and under-taking activities to accomplish those goals;

(F) living independently; or

(G) economic self-sufficiency; and

(4) reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

(aaaa) "Out-of-state provider" means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. The following shall be considered out-of-state providers if they are physically located beyond the border of Kansas:

- (1) Nursing facilities;
- (2) intermediate care facilities;
- (3) community mental health centers;
- (4) partial hospitalization service providers; and
- (5) alcohol and drug program providers.

(bbbb) "Outpatient treatment" means services provided by the outpatient department of a hospital, a facility that is not under the administration of a hospital, or a physician's office.

(cccc) "Over-the-counter" means any item available for purchase without a prescription order.

(dddd) "Owner" means a sole proprietor, member of a partnership, or a corporate stockholder with five percent or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly held corporations.

(eeee) "Partial hospitalization program" means an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and daily living skills treatment modalities, based upon a treatment plan.

(ffff) "Participating provider" means any individual or entity that presently has an agreement with the agency to furnish medicaid services.

(gggg) "Pharmacy" means the premises, laboratory, area, or other place meeting these conditions:

- (1) Where drugs are offered for sale, the profession of pharmacy is practiced, and prescriptions are compounded and dispensed;
- (2) that has displayed upon it or within it the words "pharmacist," "pharmaceutical chemist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "drug sundries," or any combinations of these words or words of similar import; and
- (3) where the characteristic symbols of pharmacy or the characteristic prescription sign "Rx" are exhibited. The term "premises" as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

(hhhh) "Pharmacist" means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

(iiii) "Physical therapy" means treatment that meets these criteria:

- (1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;
- (2) is rehabilitative and restorative in nature;
- (3) is provided following physical debilitation due to acute physical trauma or physical illness; and
- (4) is prescribed by the attending physician.

(jjjj) "Physician extender" means a person registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided, and who is working under supervision as required by law or administrative regulation.

(kkkk) "Practitioner" means any person licensed to practice medicine and surgery, dentistry, or podiatry, or any other person licensed, registered, or otherwise authorized by law to administer, prescribe, and use prescription-only drugs in the course of professional practice.

(llll) "Prescribed" means the issuance of a prescription order by a practitioner.

(mmmm) "Prescription" means either of the following:

- (1) A prescription order; or
- (2) a prescription medication.

(nnnn) "Prescription medication" means any drug, supply, or device that is dispensed according to a prescription order. If indicated by the context, the term "prescription medication" may include the label and container of the drug, supply, or device.

(oooo) "Prescription-only" means an item available for purchase only with a prescription order.

(pppp) "Primary care case management" or "PCCM" means a type of managed care whereby a beneficiary is assigned a primary care case manager who manages costs and quality of services by providing case assessment, primary services, treatment planning, referral, and follow-up in order to ensure comprehensive and continuous service and coordinated reimbursement.

(qqqq) "Primary diagnosis" means the most significant diagnosis related to the services rendered.

(rrrr) "Prior authorization" means the approval of a request to provide a specific service before the provision of the service.

(ssss) "Program" means the Kansas medicaid/medikan program.

(tttt) "Proper interest" means interest incurred at a rate not in excess of what a prudent borrower would have had to pay under market conditions existing at the time the loan was made.

(uuuu) "Prospective, reasonable, cost-related reimbursement" means present and future reimbursement, based on analysis and consideration of historical costs related to patient care.

(vvvv) "Qualified medicare beneficiary" or "QMB" means an individual meeting these requirements:

- (1) Who is entitled to medicare hospital insurance benefits under part A of medicare;
- (2) whose income does not exceed a specified percent of the official poverty level as defined by the United States executive office of management and budget; and

(3) whose resources do not exceed twice the supplemental security income resource limit.

(www) "Readmission" means the subsequent admission of a consumer as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another DRG hospital.

(xxxx) "Related parties" means two or more parties to a transaction, one of which has the ability to influence the other or others in a way in which each party to the transaction might fail to pursue its own separate interests fully. Related parties shall include those related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

(yyyy) "Related to the community mental health center" means that the agency or facility furnishing services to the community mental health center meets any of these requirements:

- (1) Is directly associated or affiliated with the community mental health center by formal agreement;
- (2) governs the community mental health center; or
- (3) is governed by the community mental health center.

(zzzz) "Residence for the payment of hospice services" means a hospice consumer's home or the nursing facility in which a hospice consumer is residing.

(aaaa) "Revocation statement" means the statement signed by the consumer that revokes the election of hospice service.

(bbbb) "Sampling" means the review process of obtaining a stratified random sample of a subset of cases from the universe of claims submitted by a specific provider. The sample shall be used to project the review results across the entire universe of claims for that provider to determine an overpayment.

(cccc) "Speech therapy" means treatment provided by a speech pathologist who has a certificate of clinical competence from the American speech and hearing association. The treatment shall meet these requirements:

- (1) Be rehabilitative and restorative in nature;
- (2) be provided following physical debilitation due to acute physical trauma or physical illness; and
- (3) be prescribed by the attending physician.

(dddd) "Standard diagnosis-related group amount" or "standard DRG amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis-related group weight.

(eeee) "State-operated hospital" means an establishment operated by the state of Kansas that provides diagnosis and treatment for nonrelated patients and includes the following:

- (1) An organized medical staff of physicians;
- (2) permanent facilities that include inpatient beds; and

(3) medical services that include physician services and continuous registered professional nursing services for 24 hours each day.

(ffff) "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

(ggggg) "Swing bed" means a hospital bed that can be used interchangeably as a hospital, skilled nursing facility, or intermediate care facility bed, with reimbursement based on the specific type of care provided.

(hhhhh) "Targeted case management services" means those services that assist medicaid consumers in gaining access to medically necessary care. The services shall be provided by a case manager with credentials specified by the secretary.

(iiii) "Terminally ill" means that an individual has a life expectancy of six months or less as determined by a physician.

(jjjj) "Timely filing" means the receipt by the agency or its fiscal agent of a claim for payment filed by a provider for services provided to a medicaid program consumer not later than 12 months after the date the claimed services were provided.

(kkkkk) "Transfer" means the movement of an individual receiving general hospital inpatient services from one hospital to another hospital for additional, related inpatient care after admission to the previous hospital or hospitals.

(llll) "Transferring hospital" means the hospital that transfers a consumer to another hospital. There may be more than one transferring hospital for the same consumer until discharge.

(mmmm) "Uncollectable overpayment to an out-of-business provider" means either of the following:

(1) Any amount that is due from a provider of medical services who has ceased all practice or operations for any medical services as an individual, a partnership, or a corporate identity, and who has no assets capable of being applied to any extent toward a medicaid overpayment; or

(2) any amount due that is less than its collection and processing costs.

(nnnn) "Urgent" means that a situation requires medical treatment within two days of onset, but not through the emergency room.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended Jan. 2, 1990; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended, T-30-3-1-91, March 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended May 1, 1992; amended July 31, 1992; amended May 3, 1993; amended Oct. 1, 1993; amended July 1, 1994; amended April 1, 1995; amended Sept. 1, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended July 6, 2001.

30-5-59. Provider participation requirements. The following shall be prerequisites for participation in and payment from the medicaid/medikan program. Any provider of services to foster care consumers, adoption support consumers, Kan Be Healthy consumers, or other consumers who have special needs may be excluded from these prerequisites if the secretary determines that a medically necessary item of durable medical equipment can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled within the current program guidelines.

(a) Enrollment. Each participating provider shall perform the following:

(1) Submit an application for participation in the medicaid/medikan program on forms prescribed by the secretary of the Kansas department of social and rehabilitation services;

(2) obtain and maintain professional or department-specified credentials determined by the secretary in the jurisdiction where the service is provided and for the time period when the service is provided and, if applicable, be certified, licensed, or registered by the appropriate professional credentialing authority;

(3) notify the Kansas department of social and rehabilitation services if any of the original information provided on the application changes during the term of participation in the medicaid/medikan program;

(4) after completing the necessary application forms and receiving notice of approval to participate from the department, enter into and keep a provider agreement with the Kansas department of social and rehabilitation services;

(5) notify the Kansas department of social and rehabilitation services when a change of provider ownership occurs, submit new ownership information on forms for application for participation in the medicaid/medikan program, and receive approval from the department for participation as a new provider before reimbursement for services rendered to medicaid/medikan program consumers is made;

(6) locate a consumer service representative who is available 24 hours per day and a business in Kansas or a border city that is accessible, in accordance with the applicable Americans with disabilities act guidelines, to the general public between the hours of 9:00 a.m. and 5:00 p.m. at a minimum, excluding weekends and state and federal holidays, if applying to be a durable medical equipment or medical supply provider. Any pharmacy located in Kansas or a border city that has a medical provider number may enroll as a durable medical equipment provider even if no storefront is present; and

(7) be located in Kansas or a border city if applying to be a pharmacy, unless the pharmacy is providing services to children in the custody of the secretary of the Kansas department of social and rehabilitation services or to program consumers in emergency situations. The only exceptions to this requirement shall be the following:

(A) A pharmacy that is an approved contractor with the Kansas department of health and environment as a supplier of intravenous blood fraction products. This exception shall apply only to reimbursement for the intravenous blood fraction products; and

(B) a mail order pharmacy that serves medicaid consumers with a primary payor other than medicaid.

(b) Denial of application. If an application for participation in the medicaid/medikan program is denied, the applicant shall be notified in writing by the department.

(c) Continuing participation. Each participating provider shall perform the following:

(1) Comply with applicable state and federal laws, regulations, or other program requirements;

(2) comply with the terms of the provider agreement;

(3) submit accurate claims or cost reports;

(4) submit claims only for covered services provided to consumers;

(5) engage in ethical and professional conduct;

- (6) provide goods, services, or supplies that meet professionally recognized standards of quality;
- (7) submit a new application for participation in the medicaid/medikan program if a claim has been submitted for payment and if at least 18 months have elapsed since a previous claim for payment was submitted; and
- (8) refund any overpayment to the program within a period of time specified by the secretary or lose eligibility to participate.

(d) Recordkeeping. Each participating provider shall perform the following:

(1) Maintain and furnish within the time frame specified in a request any information for five years from the date of service that the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity may request to ensure proper payment by the medicaid/medikan program, to substantiate claims for medicaid/medikan program payments, and to complete determinations of medicaid/medikan program overpayments. This information shall include the following:

- (A) Fiscal, medical, and other recordkeeping systems;
- (B) matters of the provider's ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;
- (C) documentation of asset acquisition, lease, sale, or other action;
- (D) franchise or management arrangements;
- (E) matters pertaining to costs of operation;
- (F) amounts of income received, by source and purpose; and
- (G) a statement of changes in financial position;

(2) use standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the provider's field;

(3) permit the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the medicaid/medikan program; and

(4) agree to repay overpayment determinations resulting from the use of sampling techniques.

(e) Payment. Each participating provider shall meet the following conditions:

(1) Accept as payment in full, subject to audit when applicable, the amount paid by the medicaid/medikan program for covered services;

(2) not assign medicaid/medikan program claims or grant a power of attorney over or otherwise transfer right to payment for these claims except as set forth in 42 CFR 447.10, revised July 24, 1996, which is adopted by reference;

(3) not charge medicaid/medikan program consumers for services denied for payment by the medicaid/medikan program because the provider has failed to meet a program requirement including prior authorization;

(4) not charge any medicaid/medikan program consumer for noncovered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for noncovered services;

(5) not charge medicaid/medikan program consumers for services covered by the program, with the exception of claims liable to spenddown or copayment;

(6) submit claims for payment on claim forms approved and prescribed by the secretary; and

(7) be subject to the payment limitations specified in K.A.R. 30-5-70.

(f) Provider participation in the medicaid/medikan program may be disallowed for any of the reasons set forth in K.A.R. 30-5-60.

(g) This regulation shall be effective on and after January 1, 2004.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended May 1, 1992; amended May 3, 1993; amended Dec. 30, 1994; amended April 1, 1995; amended Oct. 1, 2000; amended Jan. 1, 2004.

30-5-60. Provider termination/suspension.

(a) Any provider's participation in the medicaid/medikan program may be terminated for one or more of the following reasons:

(1) Voluntary withdrawal of the provider from participation in the program;

(2) non-compliance with applicable state laws, administrative regulations, or program issuances concerning medical providers;

(3) non-compliance with the terms of a provider agreement;

(4) non-compliance with the terms and certification set forth on claims submitted to the agency for reimbursement;

(5) assignment, granting a power of attorney over, or otherwise transferring right to payment of program claims except as set forth in 42 U.S.C. 1396a (32), revised July 18, 1984, which is adopted by reference;

(6) pattern of submitting inaccurate billings or cost reports;

(7) pattern of submitting billings for services not covered under the program;

(8) pattern of unnecessary utilization;

(9) unethical or unprofessional conduct;

(10) suspension or termination of license, registration, or certification;

(11) provision of goods, services, or supplies harmful to individuals or of an inferior quality;

(12) civil or criminal fraud against medicare, the Kansas medicaid/medikan or social service programs, or any other state's medicaid or social service programs;

(13) suspension or exclusion by the secretary of health and human services from the title XVIII or title XIX programs;

(14) direct or indirect ownership or controlling interest of five percent or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicaid/medikan or social service programs or any other state's medicaid or social service programs;

(15) employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicaid/medikan or social service programs or any other state's medicaid or social service programs;

(16) insolvency; or

(17) other good cause.

(b) Termination, unless based upon civil or criminal fraud against the program, suspension or exclusion by the secretary of health and human services, shall remain in effect until the agency determines that the reason for the termination has been removed and that there is a reasonable assurance that it shall not recur. Terminations based upon civil or criminal fraud shall remain in effect for such time period as deemed appropriate by the agency. Termination based upon suspension or exclusion by the secretary of health and human services (HHS) shall remain in effect no less than the time period specified in HHS' notice of suspension.

(c) Prior to the termination of a provider from the program, the provider shall be sent a written notification by the agency of the proposed termination and the reasons. The notice shall state whether payment liability to the provider has been suspended pending further proceedings. The notice shall further advise the provider that an appearance before the section may be permitted at a specified time, not less than five days nor more than 15 days from the date the notice is mailed to or served upon the provider. At the appearance the provider may present any relevant evidence and have an opportunity to be heard on the question of continuing eligibility in the program. All evidence presented, including that of the provider, shall be considered by the agency. If the decision is to terminate, a written order of termination shall be issued, setting forth the effective date of the termination and the basic underlying facts supporting the order.

(d) Any provider found not to be in compliance with one or more requirements set forth in K.A.R. 30-5-59 may be subject to suspension of payment or other remedies in lieu of termination. The effective date of this regulation shall be May 3, 1993.

Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective May 1, 1981; amended May 1, 1986; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 3, 1993.

30-5-61a. Withholding of payments to medical providers.

(a) Payments otherwise authorized to be made to medical providers shall be withheld, in full or in part, by the agency when:

(1) The agency has determined that the provider to whom payments are to be made has been overpaid;

(2) the agency has reliable evidence, although additional evidence may be needed for a determination, that an overpayment exists or that the payment to be made may not be correct; or

(3) the agency has been instructed by the department of health and human services (HHS) to withhold all or part of the federal share from payment to a medical provider.

(b) A withholding action shall become effective immediately unless a later date is set forth in the letter of notification. The agency, no later than the effective date of the withholding action, shall send written notification of the withholding and the reasons therefor to the affected medical provider.

(c) A withholding action shall remain in effect until:

(1) The overpayment is recouped from the amount withheld or is otherwise recovered;

(2) the agency enters into an agreement with the provider for recovery of the over payment;

(3) the agency, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment; or

(4) the agency is otherwise notified by HHS if the withholding action is pursuant to federal instructions. No payment for the withheld federal share shall be made to any medical provider unless the agency receives notification from HHS to do otherwise.

(d) Whenever payments to a medical provider are withheld pursuant to paragraph (a)(2), the agency shall take timely action to obtain any additional evidence the agency may need to make a determination as to whether an overpayment exists or whether payments should be made. The agency shall make all reasonable efforts to expedite the determination. As soon as the determination has been made, the provider shall be informed and, when appropriate, the withholding action shall be rescinded or adjusted to take into account the determination. If not rescinded, the withholding action shall remain in effect as specified in paragraph (c) above.

Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.

30-5-61b. Suspension of payment liability to medical providers.

(a) Suspension of payment liability because of determination by the secretary of health and human services. The agency shall suspend payment liability for services provided by any medical provider during any time period in which payments may not be made to the provider under titles XVIII or XIX of the social security act because of a determination by the secretary of health and human services pursuant to 42 U.S.C.A. 1395y(d)(1) and (e)(1), clause (C)(ii), (D), (E) or (F) of 42 U.S.C.A. 1395cc (b)(2). The suspension shall be effective upon receipt of the notification of the determination by the department of health and human services (HHS) and shall remain in effect until the agency is otherwise notified by HHS. The agency, no later than the effective date of the suspension, shall send written notification of the suspension and the reasons therefore to the affected medical provider. No payment shall be made to any medical provider for services provided by the medical provider during the time period of suspension unless the agency receives notification from HHS to do otherwise.

(b) Suspension of payment liability upon notification of proposed termination.

(1) Payment liability may be suspended by the agency upon notification to a provider of a proposed termination if the provider may no longer legally provide services or for other good cause. No payment shall be made to a provider for services rendered after the provider receives notification of the suspension.

(2) If payment liability is suspended to an adult care home, payment liability for those program recipients who are living in the home at the time of the suspension may be continued, for a period not to exceed 30 days, to facilitate the orderly transfer of the recipients to another facility or to alternate care.

Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.

30-5-62. Reinstatement of a provider previously terminated from the medicaid/medikan program. A request for reinstatement by a provider terminated from participation in the medicaid/medikan program shall not be

considered for a period of 60 days following the effective date of the order of termination. As a prerequisite for reinstatement in the program one or more of the following conditions may be imposed by the agency:

- (a) Implementation and documentation of corrective action taken by the provider to comply with program policies and to reasonably insure that the reason for the termination shall not recur;
- (b) probationary period not to exceed one year;
- (c) attendance at provider education sessions;
- (d) prior authorization of services;
- (e) peer supervision; and
- (f) other conditions as the specific situation may warrant.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.

30-5-63. Medical necessity. Except as specifically set forth in program policy, the agency shall not reimburse a provider for the provision of a covered service to a program recipient unless the provision of the service was medically necessary.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.

30-5-64. Prior authorization.

(a) Any medical service may be placed by the secretary on the published list of services requiring prior authorization or precertification for any of the following reasons:

- (1) To ensure that provision of the service is medically necessary;
- (2) to ensure that services that may be subject to over-use are monitored for appropriateness in each case; and
- (3) to ensure that services are delivered in a cost-effective manner.

(b) Administration of covered pharmaceuticals in the following classes shall require prior authorization. A cross-reference of generic and brand names shall be made available upon request:

- (1) Ace inhibitors:
 - (A) Benazepril;
 - (B) fosinopril;
 - (C) moexipril;
 - (D) perindopril;
 - (E) quinapril;
 - (F) ramipril; and
 - (G) trandolopril;

- (2) acne and skin lesion products:
- (A) Tretinoin; and
 - (B) alitretinoin;
- (3) angiotensin II receptor antagonists:
- (A) Candesartan;
 - (B) eprosartan;
 - (C) irbesartan;
 - (D) olmesartan; and
 - (E) valsartan;
- (4) antipsoriatics: alefacept;
- (5) antiretroviral drugs: enfuvirtide;
- (6) antirheumatics:
- (A) Leflunomide;
 - (B) infliximab;
 - (C) anakinra;
 - (D) adalimumab; and
 - (E) etanercept;
- (7) cervical dystonias: botulinum toxins A and B;
- (8) drugs for the treatment of osteoporosis: teriparatide;
- (9) antituberculosis products:
- (A) Aminosalicylate sodium;
 - (B) capreomycin;
 - (C) ethambutol;
 - (D) ethionamide;
 - (E) isoniazid;
 - (F) pyrazinamide; and
 - (G) rifampin and rifampin/isoniazid combinations;

(10) benzodiazepines:

- (A) Alprazolam;
- (B) clorazepate dipotassium; and
- (C) diazepam;

(11) all decubitus and wound care products;

(12) all intravenous and oral dietary and nutritional products, including the following:

- (A) Amino acids, injectable;
- (B) l-cysteine;
- (C) lipids, injectable; and
- (D) sodium phenylbutyrate;

(13) beta-blockers:

- (A) Betaxolol;
- (B) bisoprolol;
- (C) carteolol;
- (D) nadolol;
- (E) penbutolol;
- (F) pindolol; and
- (G) timolol;

(14) calcium channel blockers:

(A) Diltiazem extended release, with the following brand names:

- (i) Cardizem SR(R);
- (ii) Cardizem CD(R);
- (iii) Cartia XT(R); and
- (iv) Dilacor XR(R);

(B) verapamil sustained release, with the following brand names:

- (i) Covera HS(R); and
- (ii) Verelan PM(R); and

C) nifedipine sustained release products;

(15) all cyclooxygenase 2 (cox 2) inhibitors:

- (A) Celecoxib;
- (B) rofecoxib; and
- (C) valdecoxib;

(16) all growth hormones and growth hormone stimulating factor, including the following:

- (A) Somatrem;
- (B) somatropin; and
- (C) sermorelin;

(17) modafinil;

(18) intranasal corticosteroids:

- (A) Budesonide;
- (B) mometasone;
- (C) beclomethasone; and
- (D) triamcinolone;

(19) proton pump inhibitors:

- (A) Esomeprazole;
- (B) omeprazole; and
- (C) rabeprazole;

(20) drugs for the treatment of impotence: alprostadil;

(21) monoclonal antibody for respiratory syncytial virus (RSV), including palivizumab;

(22) muscle relaxants:

- (A) Tizanidine;
- (B) orphenadrine;
- (C) methocarbamol;
- (D) carisprodol;
- (E) carisprodol compound;
- (F) cyclobenzaprine (5 mg); and
- (G) metaxolone;

- (23) nonsteroidal, anti-inflammatory drugs: meloxicam;
- (24) drugs for the treatment of obesity:
- (A) Orlistat; and
 - (B) sibutramine;
- (25) oxazolidinones, including linezolid;
- (26) HMG-CoA reductase inhibitors: pravastatin;
- (27) nonsedating antihistamines:
- (A) Desloratidine;
 - (B) fexofenadine;
 - (C) Claritin(R); and
 - (D) cetirizine;
- (28) H₂ antagonists: nizatidine;
- (29) triptans:
- (A) Naratriptan;
 - (B) zolmitriptan;
 - (C) almotriptan;
 - (D) frovatriptan; and
 - (E) eletriptan HBr;
- (30) oral antidiabetic drugs:
- (A) Amaryl(R);
 - (B) Glucotrol XL(R);
 - (C) Starlix(R);
 - (D) Precose(R);
 - (E) Glucophage XR(R);
 - (F) Glucovance(R); and
 - (G) Metaglip(R);
- (31) all 3.0 ml syringes and 3.0 ml cartridges of insulin, including the following:
- (A) Humalog(R);

(B) Humalog Mix(R);

(C) Novolog(R); and

(D) Novolog Mix(R);

(32) serotonin 5-HT[3] receptor antagonist antiemetics:

(A) Kytril(R); and

(B) Anzemet(R);

(33) influenza vaccines: Flumist(R); and

(34) the following drugs if specifically required by the physician, which shall require prior authorization to override maximum allowable cost (MAC) or federal upper limit (FUL) pricing:

(A) Clozaril;

(B) depakene;

(C) tegretol; and

(D) coumadin.

(c) Failure to obtain prior authorization, if required, shall negate reimbursement for the service and any other service resulting from the unauthorized or noncertified treatment. The prior authorization shall affect reimbursement to all providers associated with the service.

(d) The only exceptions to prior authorization shall be the following:

(1) Emergencies. If certain surgeries and procedures that require prior authorization are performed in an emergency situation, the request for authorization shall be made within two working days after the service is provided.

(2) Situations in which services requiring prior authorization are provided and retroactive eligibility is later established. When an emergency occurs or when retroactive eligibility is established, prior authorization for that service shall be waived, and if medical necessity is documented, payment shall be made.

(e) Services requiring prior authorization shall be considered covered services within the scope of the program unless the request for prior authorization is denied.

Authorized by K.S.A. 39-708c(b) and K.S.A. 2003 Supp. 39-7,120; implementing K.S.A. 2003 Supp. 39-7,120 and 39-7,121a; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended May 1, 1992; amended July 1, 1994; amended March 1, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended Jan. 1, 1999; amended April 1, 2000; amended Oct. 1, 2000; amended Oct. 1, 2001; amended Dec. 6, 2002; amended Feb. 21, 2003; amended May 9, 2003; amended July 11, 2003; amended Aug. 8, 2003; amended Nov. 14, 2003; amended Dec. 29, 2003; amended May 28, 2004.

30-5-65. Filing limitations for medical claims. Each claim for payment shall be received by the Kansas department of social and rehabilitation services or its fiscal agent within 12 months after the date of service. Each medical claim which has been denied for payment shall be resubmitted to and received by the department or its fiscal agent within 24 months of the date of service and in conformance with all billing requirements of the medicaid/medikan program or payment shall not be made. The only exceptions shall be:

- (a) claims for services provided to a child who at the time of service was in the custody of the secretary or a child for whom the agency has entered into an adoptive support agreement if the medical provider did not have knowledge of the custody or the agreement;
- (b) claims submitted to Medicare within 12 months after the date of service, paid or denied for payment by Medicare, and subsequently received by the Kansas medical assistance program within 30 days after the Medicare payment or denial date;
- (c) claims determined payable by reason of administrative appeals, court action or agency error;
- (d) claims for emergency services rendered by out-of-state providers who are not already enrolled as program providers; or
- (e) claims arising out of circumstances described under subsections (a), (b), (c) or (d) and determined not to be payable under any such item, but which the secretary determines that such claims were the result of extraordinary circumstances. The effective date of this regulation shall be July 1, 1994.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 1, 1992; amended July 1, 1994.

30-5-66. Effective date of administrative regulations in relationship to provider cost reporting periods. The administrative regulations in effect at the beginning of a cost reporting period shall govern the treatment of costs that accrue during said period unless otherwise provided.

Authorized by and implementing K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.

30-5-67. Disallowance of claims for services generated by providers ineligible for participation in the medicaid/medikan program. The agency shall disallow payment, except for emergency services, if the service set forth on a claim was generated by a provider ineligible to participate in the medicaid/medikan program.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.

30-5-68. Consultants to the medicaid/medikan program. Consultants to the medicaid/medikan program may be reimbursed if under contract with the Kansas department of social and rehabilitation services. The payment rate for consultants shall be a mutually negotiated amount. The effective date of this regulation shall be August 1, 1990.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990.

30-5-69. Volume purchase and negotiated contracts for medical services. The agency may procure medical services from a single or multiple source through competitive bidding or negotiated fee. The agreed upon reimbursement shall supersede the usual reimbursement methodology for the service.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982.

30-5-70. Payment of medical expenses for eligible recipients.

(a) Payment for covered services shall be made only to those providers participating in the program pursuant to K.A.R. 30-5-59. The only exceptions shall be pursuant to K.A.R. 30-5-65.

(b) Each program recipient shall be eligible for the payment of specific medical expenses as follows:

(1) Payment of Medicare (title XVIII) premiums and deductibles and co-insurance amounts for services covered in the medicaid program. Recipients who are ineligible for program coverage because they have a spenddown shall be eligible for the payment of the Medicare (title XVIII) premium expense. For cash recipients, including SSI recipients, who are age 65 or older, payment of the Medicare (title XVIII) premium shall begin with the month of approval for medicaid, excluding any months of prior eligibility. For recipients under age 65 who are eligible for Medicare after receiving retirement and survivor's disability insurance for 24 consecutive months, payment of the Medicare (title XVIII) premium shall begin with the 25th month. For all other recipients, payment of the Medicare (title XVIII) premium shall begin with the second month following the month of approval for medicaid, excluding any months of prior eligibility;

(2) payment of premiums of health maintenance organizations that are approved by the agency or premiums of group health plans offered by the recipient's employer if the agency has determined that this plan is cost-effective;

(3) payment of other allowable medical expenses incurred in the current eligibility base period in excess of any co-pay or spenddown requirements;

(4) payment for services rendered to a person who is mandated to receive inpatient treatment for tuberculosis and who is not otherwise eligible for participation in the program. Coverage shall be limited to services related to the treatment for tuberculosis;

(5) payment for services in excess of medicaid/medikan program limitations for foster care and adoption support recipients, when approved by the agency; and

(6) payment for covered medical services provided to an individual participating in the KanWork program. A monthly cost-sharing amount for medical services shall be paid by each individual participating in the KanWork program when required.

(c) The scope of services provided to recipients and the payment for those services shall be as set forth in articles 5 and 10 of this chapter, subject to the following limitations.

(1) Payment for a particular medical expense shall be denied if it is determined that any one of these conditions is met:

(A) The recipient failed to utilize medical care available through other community resources, including public institutions, veterans administration benefits, and those laboratory services that are available at no charge through the state department of health and environment.

(B) A third party liability for the medical expense has been established and is available.

(C) The recipient fails to make a good faith effort to establish a third party liability for the medical expense or fails to cooperate with the agency in establishing the liability. Payment of a medical expense may be delayed pending the outcome of a determination concerning third party liability.

(D) The expense is not covered or is only partially covered by an insurance policy because of an insurance program limitation or exclusion.

(E) The recipient failed to notify the provider of services of the recipient's eligibility for the program.

(F) The service is cosmetic, pioneering, or experimental, or is a result of complications related to these procedures.

(G) The service is related to transplant procedures that are not covered by the medicaid/medikan program.

(H) The service was provided by a provider not designated as a lock-in provider for any recipient who is locked into designated providers due to abuse, unless the provider has a written referral from a designated provider or unless the service was an emergency service.

(I) The service was provided by a provider not designated as the primary care case manager for any recipient who is enrolled in the primary care case manager program, unless the provider has a written referral from the designated provider or unless the service was an emergency service.

(J) The service was covered in a health maintenance organization plan for any recipient enrolled in a health maintenance organization.

(K) The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the medicaid/medikan program.

(L) The service exceeds the limitations defined by the program policies.

(2) Payment for out-of-state services shall be limited to the following:

(A) Payment on behalf of recipients if medical services are normally provided by medical vendors that are located in the bordering state and within 50 miles of the state border, except for community mental health center services, alcohol and drug abuse services, or partial hospitalization services;

(B) emergency services rendered outside the state;

(C) nonemergency services for which prior approval by the agency has been given. Authorization from the agency shall be obtained before making arrangements for the individual to obtain the out-of-state services;

(D) services provided by independent laboratories; and

(E) medical services provided to foster care recipients and medical services in excess of the limitations of the state of residence, when approved by the Kansas department of social and rehabilitation services and within the scope of the adoption agreement for those for whom Kansas has initiated adoption support agreements.

(3) The scope of services for adult non-medicaid (non-title XIX) program recipients shall be limited as set forth in K.A.R. 30-5-150 through 30-5-172.

(d) Payment for medical services shall be made, at the discretion of the secretary, when it has been determined that an agency administrative error has been made.

(e) This regulation shall take effect on and after October 1, 1998.

Authorized by and implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended May 1, 1985; amended

May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended May 3, 1993; amended July 19, 1996; amended Oct. 1, 1998.

30-5-71. Copayment requirements.

(a) Except as set forth in subsection (b) of this regulation, program recipients shall be obligated to the provider for the following copayment charges.

(1) The copayment for inpatient general hospital and freestanding psychiatric facility services shall be \$ 48.00 per admission.

(2) The copayment for outpatient general hospital services shall be \$ 1.00 per non-emergency visit in place of a doctor's office visit.

(3) The copayment for other medical services subject to copayment shall be based upon the following ranges:

| average medicaid/medikan payment for services | maximum copayment chargeable to recipient |
|--|--|
| \$ 10.00 or less | \$.50 |
| \$ 10.01 to \$ 25.00 | \$ 1.00 |
| \$ 25.01 to \$ 50.00 | \$ 2.00 |
| \$ 50.01 or more | \$ 3.00 |

(4) The copayment for other medical services subject to copayment shall be a standard amount based upon the average medicaid payment for the services, calculated on an annual basis. The average medicaid payment shall be calculated by dividing the cost of the services in aggregate by the total number of claims paid in the previous fiscal year. Any change in copayment shall be published in the Kansas Register on or before December fifteenth to be effective January first of each year.

(5) Other medical services subject to copayment shall include the following:

(A) Ambulatory surgical center services, for each date of service;

(B) audiological services, excluding batteries, for each date of service;

(C) community mental health center services, for each individual psychotherapy visit;

(D) durable medical equipment, prosthetics, and orthotics, for each claim, excluding the rental of durable medical equipment;

(E) home health services, for each skilled nursing visit, excluding the rental of durable medical equipment;

(F) non-emergency ambulance services, for each date of service;

(G) optometric or ophthalmologist services, for each date of service;

(H) outpatient general hospital surgery, for each date of service;

(I) prescribed drugs, for each new or refilled prescription;

- (J) physician or physician extender services, for each office visit;
- (K) podiatric services, for each office visit;
- (L) psychological services, for each office visit;
- (M) dietician services, for each date of service;
- (N) dental services, for each date of service;
- (O) federally qualified health center services, for each encounter; and
- (P) rural health clinic services, for each encounter.

(b) The provisions of subsection (a) shall not apply to services provided as follows:

- (1) To residents in nursing facilities, including swing beds, intermediate care facilities for the mentally retarded, nursing facilities for mental health, and to recipients participating in the home- and community-based services programs;
- (2) to inpatients in a state psychiatric hospital who meet both of the following conditions:
 - (A) Have reached the age of 18 but are not yet 22 years of age; or
 - (B) are at least 65 years of age;
- (3) to recipients under age 18;
- (4) to recipients in the custody of the juvenile justice authority or secretary of social and rehabilitation services who are at least 18 years old but under age 21 and who are in out-of-home placements;
- (5) to recipients enrolled in a medicaid-funded health maintenance organization;
- (6) for family planning purposes;
- (7) for medical services relating to an injury incurred on the job during a community work experience project;
- (8) for services related to pregnancy; and
- (9) for emergency services.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended, T-83-38, Nov. 23, 1982; amended May 1, 1983; amended, T-84-36, Jan. 1, 1984; amended May 1, 1984; amended May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended Dec. 31, 1992; amended Sept. 27, 1993; amended Dec. 30, 1994; amended, T-30-6-28-95, July 1, 1995; amended Sept. 1, 1995; amended July 1, 1997; amended Sept. 3, 2004.

30-5-72. Medical contracts; funding. All medical contracts shall be subject to federal and state funding conditioned by appropriations made by congress and the state legislature.

Authorized by and implementing K.S.A. 1980 Supp. 39-708; effective May 1, 1981.

30-5-73. Requirements for facilities to participate.

(a) Medical services provided in community mental health centers, free-standing psychiatric facilities, state-operated hospitals, and general hospitals to be reimbursed by the medicaid/medikan program shall be under the effective control of a physician as determined by the agency.

(b) Community mental health centers, freestanding psychiatric facilities, state-operated hospitals, and general hospitals providing medical services reimbursable by the medicaid/medikan program shall have utilization review programs approved by medicare or the agency. Utilization review programs and their implementation shall be subject to review by the secretary.

(c) Facilities offering medical services shall be licensed or certified by an appropriate Kansas state licensing or certification authority in order to be eligible for reimbursement by the medicaid/medikan program. The effective date of this regulation shall be October 1, 1993.

Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Oct. 1, 1993.

30-5-81. Scope of hospital services.

(a) Each hospital shall be medicare-certified and shall annually update medicaid enrollment information.

(b) Outpatient services shall be covered with the following limitations.

(1) Services shall be ordered by an attending physician who is not serving as an emergency room physician, except for those services related to emergency situations. Orders shall be related specifically to the present diagnosis of the recipient.

(2) A prosthetic device shall replace all or part of an internal body organ or shall replace one of these devices.

(3) (A) Rehabilitative therapies shall be restorative in nature.

(B) Rehabilitative therapies shall be provided following physical debilitation due to acute physical trauma or physical illness.

(C) Rehabilitative therapies shall be prescribed by the attending physician.

(4) Services provided in the emergency department shall be emergency services.

(5) Elective surgery shall not be covered, except for sterilization operations or operations for Kan Be Healthy program participants.

(6) Ambulance services shall not be covered.

(7) Nonemergency visits in place of physician office visits shall be considered physician office visits and shall be counted against the physician office visit limitation.

(8) Outpatient hospital assessment of the need for emergency service shall not be covered.

(c) Inpatient services shall be covered, subject to the following limitations.

(1) Services shall be ordered by a physician and shall be related specifically to the present diagnosis of the recipient.

- (2) Transplant surgery shall be limited to the following:
- (A) Liver transplants, which shall be performed only at a hospital designated by the secretary unless the medical staff of that hospital recommends another location; and
 - (B) corneal, kidney, and bone marrow transplants and related services.
- (3) A recipient of general hospital inpatient services shall not be billed for those days determined to be medically unnecessary. If a recipient refuses to leave a hospital after the recipient's physician writes a discharge order, the days after discharge that the recipient remains in the hospital may be billed to the recipient.
- (4) A provider shall not be reimbursed for services provided on the day of discharge.
- (5) Long-term care services in swing beds shall be provided pursuant to 42 CFR part 482, subpart E, revised October 1, 1999, which is adopted by reference.
- (6) A provider shall not be reimbursed on an inpatient basis for therapeutic and diagnostic surgical services, and related services that can be performed on an outpatient basis. A provider shall not be reimbursed on an inpatient basis unless the service provider documents medical necessity.
- (7) Inpatient services shall be subject to utilization review, which shall determine the following:
- (A) Whether services are medically necessary;
 - (B) whether services are furnished at the appropriate level of care;
 - (C) whether services are of a quality that meets professionally recognized standards;
 - (D) whether a discharge is premature;
 - (E) whether a transfer is necessary; and
 - (F) whether the procedure coding and the diagnosis coding on a claim are correct.
- (8) Psychotherapy, directed by a psychiatrist or approved hospital staff under the direction of a psychiatrist, shall be provided to each psychiatric patient on a daily basis.
- (9) Substance abuse treatment services shall be limited to three treatment admissions per recipient's lifetime, regardless of the type of provider.
- (10) Inpatient acute care related to substance abuse treatment services shall be limited to those patients who are in need of acute detoxification.
- (11) Elective surgery shall not be covered, except for sterilization operations or operations for Kan Be Healthy program participants.

Authorized by and implementing K.S.A. 1999 Supp. 39-708c; effective May 1, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended May 1, 1983; amended, T-84-7, March 29, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-89-24, May 27, 1988; amended Sept. 26, 1988; amended, T-30-10-28-88, Oct. 28, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-29-89, July 29, 1989; amended Nov. 24, 1989; amended Aug. 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended July 1, 1996; amended Oct. 6, 2000.

30-5-81a. Participation in the diagnosis related group reimbursement system. As a prerequisite for participation in the medicaid/medikan program, a general hospital shall participate in the Kansas department of social and rehabilitation services' diagnosis related group reimbursement system. The effective date of this regulation shall be January 1, 1989.

Authorized by and implementing K.S.A. 39-708c; effective, E-82-6, May 1, 1981; effective May 1, 1982; amended, T-84-7, May 1, 1983; amended May 1, 1984; amended July 1, 1989.

30-5-81b. The basis of reimbursement for hospital services.

(a) Payment for hospital services provided to program participants shall be made to those hospitals filing cost reports with the Kansas department of social and rehabilitation services. Cost reports shall be due 30 days after the due date of the medicare cost report to the medicare fiscal intermediary.

(b) General hospitals; inpatient services. For covered services rendered to program recipients, each general hospital shall be reimbursed on the basis of the diagnosis related group reimbursement system pursuant to the provisions of K.A.R. 30-5-81t through 30-5-81v except as set forth below.

(c) General hospitals; outpatient services. For covered services rendered to program recipients, each general hospital shall be reimbursed based on the reimbursement methodology for comparable services rendered by non-hospital providers. For laboratory and radiology services, each general hospital shall be reimbursed its customary charges not to exceed the range maximum set forth in K.A.R. 30-5-85a plus 2%.

(d) General hospitals; long term care in swing bed hospitals. For covered services rendered to program recipients, each general hospital shall be reimbursed pursuant to 42 CFR 447.250 through 447.280, revised October 1, 1988, which are adopted by reference.

(e) State-operated hospitals. Each state-operated hospital shall be reimbursed the lesser of reasonable costs or customary charges for covered inpatient services rendered to program recipients. Each state-operated hospital shall be reimbursed reasonable fees as related to customary charges for covered outpatient services rendered to program recipients, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations.

(f) Hospitals which are determined to be disproportionate share hospitals shall be reimbursed with a disproportionate share payment adjustment as determined in accordance with the Omnibus Budget Reconciliation Act, Public Law 100-203, section 4112, effective July 1, 1988. The effective date of this regulation shall be October 1, 1993.

Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1981; amended, E-82-6, May 1, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended May 1, 1983; amended, T-84-7, March 29, 1983; amended May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-87-44, Jan. 1, 1987; amended, T-88-6, March 4, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Aug. 1, 1990; amended Oct. 1, 1993.

30-5-81t. Hospital change of ownership.

(a) Agency notification and provider agreements.

(1) Each hospital shall notify the agency in writing at least 60 days prior to the effective date of the change of ownership. Failure to do so shall result in the forfeiture of rights to payment for covered services provided to recipients by the previous owner or owners in the 60-day period prior to the effective date of the change of ownership. Failure to notify the agency in writing at least 60 days prior to the effective date of the change of ownership shall result in the new owner or owners assuming responsibility for any overpayment made to the previous owner or owners before the effective date of the change of ownership.

This shall not release the previous owner of responsibility for such overpayment. This notification requirement may be waived at the discretion of the secretary based upon the showing of good cause by a hospital changing ownership. The new owner or owners shall submit an application to be a provider of services in the program and shall not receive reimbursement for covered services provided to recipients from the effective date of the change of ownership until the date upon which all requirements for participation pursuant to K.A.R. 30-5-59 have been met or until the date upon which an application to be a provider of services in the program is received by the Kansas department of social and rehabilitation services, whichever is later.

(2) At least 60 days before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the agency shall be notified in writing. If the business entity fails to provide 60 days written notice, no reimbursement shall be made. This notification requirement may be waived at the discretion of the secretary based upon the showing of good cause by a hospital changing ownership.

(3) If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of service shall be submitted to the agency by the new owner and affiliated providers.

(4) Transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of ownership. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of ownership, and an application to be a provider of services shall be submitted to the agency by the new owner and affiliated providers.

(5) Each partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the owner of the facility. Each addition or substitution to a partnership or any change of ownership resulting in a completely new partnership shall require that an application to be a provider of services shall be submitted to the agency by the new owner and affiliated providers.

(6) The change of or a creation of a new lessee, acting as a provider of services, shall constitute a change of ownership. An application to be a provider of services shall be submitted to the agency by the new lessee and affiliated providers. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in ownership.

(b) Certification surveys. Each new owner or owners shall be subject to a certification survey by the department of health and environment and, if certified, the period of certification shall be as established by the department of health and environment.

(c) Cost limitations.

(1) For each asset in existence on July 18, 1984, which is subsequently sold, the valuation of the asset for reimbursement purposes shall be the lesser of the allowable acquisition cost of the asset to the owner of record on July 18, 1984, or the acquisition cost of the asset to the new owner.

(2) For each asset not in existence on July 18, 1984, the valuation of the asset for reimbursement purposes shall be the lesser of the acquisition cost of the asset to the first owner of record or the acquisition cost of the asset to the new owner.

(3) Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, shall not be allowable. The effective date of this regulation shall be July 1, 1989.

Authorized by and implementing K.S.A. 39-708c; effective, T-85-34, Dec. 19, 1984; effective May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989.

30-5-81u. General hospital groups under the diagnosis-related group (DRG) reimbursement system.

(a) General hospitals participating in the Kansas medicaid/medikan program shall be assigned by the Kansas department of social and rehabilitation services to one of three groups. Each general hospital shall be annually notified by the department in writing of the hospital's group assignment.

(1) Each general hospital assigned to group one shall meet either of the following criteria:

(A) Be located within a metropolitan statistical area within the state of Kansas and have at least 200 general hospital inpatient beds; or

(B) be located within the state of Kansas and within 10 miles of a general hospital meeting the criteria set forth in paragraph (a)(1)(A).

(2) Each general hospital assigned to group two shall meet one of the following criteria:

(A) Be located within a metropolitan statistical area in the state of Kansas and have fewer than 200 general hospital inpatient beds;

(B) be located outside of a metropolitan statistical area in the state of Kansas or its border cities and have at least 100 general hospital inpatient beds;

(C) be located within the state of Kansas and within 10 miles of a general hospital meeting the criteria set forth in paragraph (a)(2)(A) or (B); or

(D) be located outside of the state of Kansas.

(3) A general hospital shall be assigned to group three if it does not meet the criteria specified in either paragraph (a)(1) or (a)(2) above.

(4) A general hospital shall be assigned to group one if it meets the criteria for assignment to both group one and group two.

(b) General hospital group assignments shall be redetermined annually by the department based upon the criteria in subsection (a).

Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989; amended Dec. 29, 1995; amended, T-30-1-2-03, Jan. 2, 2003; amended April 18, 2003.

30-5-81v. Reimbursement for general hospital inpatient services under the diagnosis related group (DRG) reimbursement system.

(a) The Kansas department of social and rehabilitation services shall reimburse general hospitals for inpatient services provided to recipients covered pursuant to K.A.R. 30-5-81 on the basis of the diagnosis related group (DRG) reimbursement system.

(b) Reimbursement shall be determined as follows:

(1) The standard DRG amount shall constitute reimbursement for each covered general hospital inpatient stay except in circumstances described in subsections (b)(5) and (b)(6) below. An additional payment shall be made for each day outlier or each cost outlier pursuant to subsections (b)(2), (b)(3) and (b)(4) below.

(2) If a covered general hospital inpatient stay is determined to be a cost outlier, the reimbursement for the cost outlier additional payment shall be obtained by multiplying two items: The DRG adjustment

percentage and the difference between the estimated cost of the covered inpatient stay and the cost outlier limit.

(3) If a covered general hospital inpatient stay is determined to be a day outlier, the reimbursement for the day outlier additional payment shall be obtained by multiplying three items: The DRG daily rate, the DRG adjustment percentage, and the difference between the actual covered length of inpatient stay and the day outlier limit.

(4) If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the additional payment shall be the greater of the amounts computed in subsections (b)(2) or (b)(3) above.

(5) If a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, the reimbursement to both hospitals shall be determined by a methodology specified by the secretary.

(6) Reimbursement shall not be made for a recipient's readmission to a hospital if the readmission for the same recipient is determined to have resulted from an inappropriate discharge. The effective date of this regulation shall be July 1, 1989.

Authorized by and implementing K.S.A. 39-708c; effective July 1, 1989.

30-5-82. Scope of rural health clinic services. Rural health clinic services and other ambulatory services shall be covered under the Kansas medical assistance program pursuant to 42 CFR 447.371, effective September 30, 1986, when provided by clinics accepted by the health care financing administration as qualified to furnish rural health clinic services for participation under the medicare program. A clinic may be certified as either an independent or a providerbased rural health clinic. Covered rural health clinic services and other ambulatory services shall include the following:

(a) Physician services. These are professional services performed by a physician.

(b) Advanced registered nurse practitioner and physician assistant services. These are professional services furnished by an advanced registered nurse practitioner or a physician assistant under both of the following conditions:

(1) Services are in accordance with medical orders prepared by a physician for the care and treatment of a patient.

(2) A physician is available at least once every two weeks to supervise the delivery of services and to perform services that are not in the scope of advanced registered nurse practitioner and physician assistant services as defined in the Kansas statutes.

(c) Services and related medical supplies furnished incident to professional services provided by a physician, advanced registered nurse practitioner, or physician assistant. These are services and supplies commonly furnished in physician offices under the direct supervision of a physician, advanced registered nurse practitioner, or physician assistant.

(d) Visiting nurse services. These are home health nursing services and related medical supplies provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse at the beneficiary's place of residence, which shall not include a hospital or long-term care facility, under all of the following conditions:

(1) The rural health clinic is located in an area where there is no home health agency.

(2) The services are furnished to a homebound individual who is confined to the individual's place of residence because of a medical condition.

(3) Services are provided under a written plan of treatment established by a physician, advanced registered nurse practitioner, or physician assistant and reviewed at least once every 60 days by a supervising physician.

(e) Other ambulatory services covered by a medicaid state plan.

(f) Referral for covered services not provided by the rural health clinic, to other practitioners enrolled as providers in the Kansas medical assistance program shall be covered.

(g) Screening and appropriate referral for the "kan be healthy" program shall be covered. This regulation shall take effect on and after January 1, 1999.

Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Dec. 29, 1995; amended Jan. 1, 1999.

30-5-82a. Reimbursement for rural health clinic services. Reimbursement for rural health clinic services and other ambulatory services covered by the Kansas medical assistance program shall be at reasonable cost pursuant to 42 CFR 447.371, effective September 30, 1986; 42 CFR Part 413, revised as of October 1, 1997; Section 4205 of the balanced budget act of 1997; and the provisions discussed in this regulation.

(a) Reimbursement method. An interim rate per visit shall be paid to each rural health clinic, subject to a fiscal year-end retroactive cost settlement.

(b) Interim reimbursement rate per visit.

(1) Rate for independent rural health clinic. Each clinic shall be paid by the agency the allinclusive reasonable cost rate per visit determined by the medicare carrier.

(A) Initial rate at enrollment. The medicaid payment rate shall be the current medicare rate.

(B) Rate changes. The interim payment rate of an independent rural health clinic shall be changed by the agency each time a rate change notification for that clinic is received from the medicare carrier.

(2) Rate for provider-based rural health clinic.

(A) Initial rate at enrollment. An estimated payment rate per visit that is no more than the medicare payment limit shall be set by the agency.

(B) Rate changes. After cost settlement of a provider-based clinic, the interim payment rate shall be changed by the agency based on paragraph (d)(2)(B) below.

(c) Visit. A "visit" means a face-to-face encounter between a clinic patient and a health care professional as defined in K.A.R. 30-5-82. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day shall constitute a single visit except when, after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

(d) Retroactive cost settlement. The allowable medicaid cost shall be determined by the agency, and this cost shall be compared by the agency to the total payments to determine the amount overpaid or underpaid for each cost-reporting period. "Total payments" shall include interim reimbursements, health connect Kansas case management payments, third party liability, and any other payment for covered services.

(1) Cost settlement for independent rural health clinic.

(A) Cost report. The audited medicare cost report of the independent rural health clinic received from the medicare carrier shall be used by the agency.

(B) Allowable Kansas medical assistance program cost. The allowable medicaid cost of an independent rural health clinic shall be obtained by applying the audited medicare reimbursement rate per visit to medicaid paid claims data. For independent rural health clinic providers with multiple locations, aggregate medicaid paid claims data for all clinics shall be used.

(2) Cost settlement for provider-based rural health clinic.

(A) Cost report. The audited medicare cost report of the health care organization of which the rural health clinic is a part shall be used by the agency. This cost report is provided by the medicare intermediary.

(B) Allowable Kansas medical assistance program cost. Pursuant to 42 CFR 413.9 (a) and Section 4205 of the balanced budget act of 1997, the allowable medicaid cost shall be the lowest of the following three amounts:

(i) Cost computed by using the cost report;

(ii) cost computed by applying medicare maximum rate; or

(iii) billed charges.

(e) Fiscal and statistical records and audits. The requirements in K.A.R. 30-5-118a(d) shall apply.

(f) This regulation shall take effect on and after January 1, 1999.

Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended July 1, 1994; amended Jan. 1, 1999.

30-5-87. Scope of the Kan Be Healthy program. Kan Be Healthy screenings shall be available at intervals designated by the Kansas department of social and rehabilitation services and at other medically necessary intervals for all program recipients under 21 years of age.

(a) The Kan Be Healthy medical screening shall include, but shall not be limited to, the following procedures:

(1) Comprehensive health and developmental history;

(2) comprehensive, unclothed physical examination;

(3) appropriate laboratory tests;

(4) appropriate immunizations according to age and health history;

(5) health education including anticipatory guidance; and

(6) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(b) The Kan Be Healthy dental screening shall include, but shall not be limited to, the following procedures:

(1) Comprehensive oral examination; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(c) The Kan Be Healthy vision screening shall include, but shall not be limited to, the following procedures:

(1) A vision screening; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(d) The Kan Be Healthy hearing screening shall include, but shall not be limited to, the following procedures:

(1) Appropriate hearing testing; and

(2) scheduling or referral for diagnosis and treatment necessary to correct defects and chronic conditions discovered during screening.

(e) Diagnosis and treatment to correct defects and chronic conditions discovered during screening shall include, but shall not be limited to, the following services:

(1) Eyeglasses;

(2) relief of pain and infections, restoration of teeth and maintenance of dental health;

(3) hearing aids; and

(4) other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The effective date of this regulation shall be August 1, 1990.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-6-1-90, June 1, 1990; amended Aug. 1, 1990.

30-5-87a. Reimbursement for Kan Be Healthy program services.

(a) Reimbursement for screening and appropriate referral shall be made as a fee for service established by the secretary. No fee shall be paid in excess of reasonable cost or charges, whichever is less.

(b) Reimbursement for diagnosis and treatment shall follow the guidelines established for all other provider groups in the program.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989.

30-5-88. Scope of physician services.

(a) Except as set forth in subsection (b), the program shall cover medically necessary services recognized under Kansas law provided to program recipients by physicians who are licensed to practice medicine and surgery in the jurisdiction in which the service is provided.

(b) The following services shall be excluded from coverage under the program as follows:

(1) Visits. The following types of visits shall be excluded:

(A) Office visits when the only service provided is an injection or some other service for which a charge is not usually made;

(B) psychotherapy services when provided concurrently by the same provider with both targeted case management services and partial hospitalization services;

(C) psychotherapy services exceeding an average of 32 hours of individual therapy or 32 hours of group therapy or any combination of these per calendar year per recipient, unless the recipient is a Kan Be Healthy program participant and either of these conditions is met:

(i) Psychotherapy services do not exceed 40 hours per calendar year per Kan Be Healthy program participant.

(ii) Psychotherapy services are being rendered pursuant to a plan approved by the agency. The provider of psychotherapy services shall obtain prior authorization for the plan. The plan shall not exceed a two-year period and shall be subject to a reimbursement limit established by the secretary. Quarterly progress reports shall be submitted to the division of medical programs;

(D) inpatient hospital visits in excess of those allowable days for which the hospital is paid or would be paid if there were no spenddown requirements; and

(E) nursing home visits in excess of one per month, unless the service provider documents medical necessity.

(2) Consultations. The following types of consultations shall be excluded:

(A) Consultations for which there is no written report;

(B) inpatient hospital consultations in excess of one per condition per 10-day period, unless written documentation confirming medical necessity is attached to the claim; and

(C) other consultations in excess of one per condition per 60-day period, unless written documentation confirming medical necessity is attached to the claim.

(3) Surgical procedures. The following surgical procedures shall be excluded:

(A) Procedures that are experimental, pioneering, cosmetic, or designated as non-covered;

(B) all transplant surgery except for the following:

(i) Liver transplants, which shall be performed only at a hospital designated by the secretary, unless the medical staff of that hospital recommends another location; and

(ii) corneal, heart, kidney, and bone marrow transplants and related services;

(C) services of a surgical assistant when the surgeon determines that an assistant is not required for a particular surgery; and

(D) elective surgery, except for sterilization operations, or for Kan Be Healthy program participants.

(4) Miscellaneous procedures. The following types of miscellaneous procedures shall be excluded:

(A) Diagnostic radiological and laboratory services, unless the services are medically necessary to diagnose or treat injury, illness, or disease;

(B) physical therapy, unless these conditions are met:

(i) The therapy is performed by a physician or registered physical therapist under the direction of a physician; and

(ii) The therapy is prescribed by the attending physician;

(C) medical services of medical technicians, unless the technicians are under the direct supervision of a physician; and

(D) inpatient services that were provided on days of a hospital stay and that are determined to not be medically necessary.

(5) Family planning services and materials.

(A) Family planning services and materials shall be excluded, unless these conditions are met:

(i) The services are provided by a physician, family planning clinic, or county health department.

(ii) Written informed consent from the consumer is obtained as required by federal law and regulation.

(iii) The scope of services provided is in compliance with applicable federal and state statutes and regulations.

B) Reverse sterilizations shall be excluded.

(6) Concurrent care. Concurrent care shall be excluded, unless these conditions are met:

(A) The patient has two or more diagnoses involving two or more systems.

(B) the special skills of two or more physicians are essential in rendering quality medical care. The occasional participation of two or more physicians in the performance of one procedure shall be recognized. Each physician involved shall submit that physician's usual charge for only that portion of the procedure for which the physician is actually responsible.

(7) Psychological services for an individual entitled to receive these services as a part of care or treatment from a facility already being reimbursed by the program or by a third party payor shall be excluded.

(c) Services provided by physician extenders shall be covered.

(d) This regulation shall take effect on and after July 1, 1998.

Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-89-24, May 27, 1988; amended Sept. 26, 1988; amended, T-30-10-28-88, Oct. 28, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-29-89, July 29, 1989; amended Nov. 24, 1989; amended Aug. 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended July 1, 1996; amended July 1, 1998.

30-5-88a. Reimbursement for physician services.

(a) Reasonable fees as related to customary charges shall be paid for physician services, except no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations.

(b-) The maximum rate for services provided by a physician extender shall be 75% of that allowed for the physician who is billing for the physician extender services.

Authorized by and implementing K.S.A. 1982 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983.

30-5-106. Scope of ambulance services.

(a) General provisions of coverage. Ambulance services shall be available to program recipients. Services shall include the following:

- (1) emergency transportation to a facility where medical services will be rendered; and
- (2) non-emergency transportation of a recipient between the recipient's residence and a medical facility in the recipient's local community or the nearest facility able to render the medically necessary services, and transportation of a patient from one medical facility to another medical facility when the original facility provides inadequate services for treating the patient. Transportation under this paragraph shall require prior authorization for designated services.

(b) Limitations.

- (1) The ambulance service shall be licensed.
- (2) The recipient's condition shall be such that the use of any other method of transportation is not possible without endangering the health of the recipient.
- (3) The use of licensed ambulances for nonemergency wheelchair transportation shall not be covered.
- (4) Non-emergency ambulance transportation of a nursing facility resident shall not be covered.

(c) The effective date of this regulation shall be April 1, 1995.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended April 1, 1995.

30-5-106a. Reimbursement for ambulance services. Reasonable fees as related to customary charges shall be paid for ambulance services. However, no fee shall be paid in excess of the range maximum. The range of charges shall provide the base for computations.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988.

30-5-107. Scope of non-emergency medical transportation services.

(a) Non-commercial transportation, including wheelchair transportation, to and from medicaid-covered services, shall require prior authorization except for trips to receive emergency care. Services shall be provided only when transportation is not otherwise available to the recipient.

(b) The least expensive means of transportation suitable to the recipient's medical need shall be used.

(c) Non-emergency medical transportation for nursing facility residents shall not be covered.

(d) This regulation shall be effective on and after July 1, 2003.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended April 1, 1995; amended Oct. 1, 1997; amended July 1, 2003.

30-5-107a. Reimbursement for non-emergency medical transportation services.

(a) Non-commercial, non-emergency medical transportation providers shall be paid 22 cents per mile.

(b) Each commercial, non-emergency medical transportation provider shall be reimbursed at one of the following rates:

(1) For level one general transportation, \$ 10.00 for each one-way trip to a medicaid-covered service for a medicaid beneficiary, plus \$ 1.00 per mile after 10 miles; or

(2) for level two transportation for a non-ambulatory medicaid beneficiary, transportation of medical equipment with a medicaid beneficiary, or transportation of a medicaid beneficiary following a treatment that will result in a disabling physical condition, \$ 20.00 for each one-way trip to a medicaid-covered service for a medicaid beneficiary plus \$ 1.00 per mile after 10 miles.

(c) Reimbursement for necessary meals and lodging may be allowed for Kan Be Healthy participants and one attendant, subject to prior authorization.

(d) This regulation shall be effective on and after July 1, 2003.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended July 1, 2003.

30-5-108. Scope of services for durable medical equipment, medical supplies, orthotics, and prosthetics.

(a) Selected durable medical equipment (DME) shall be available to program consumers with the following limitations:

(1) The DME shall be the most economical to meet the consumer's need.

(2) The least expensive and most appropriate method of delivery shall be used. If delivery is over 100 miles round trip, prior authorization shall be required.

(3) Used equipment with a warranty guarantee specified by the division of health care policy shall be used when available.

(4) Certain DME designated by the secretary shall be the property of the agency.

(5) Educational, environmental control, and convenience items shall not be covered.

(6) DME shall be covered for only the following consumers:

(A) Participants in the Kan Be Healthy program;

(B) consumers who require the DME for life support;

(C) consumers who require the DME for employment;

(D) consumers who would require higher-cost care if the DME was not provided; or

(E) consumers who are residing in adult care homes.

(7) DME services provided for parenteral administration of total nutritional replacements and intravenous medication in the consumer's home shall require participation of nursing services from a local home health agency. In areas not served by a home health agency, the services of a local health department or advanced registered nurse practitioner shall be required.

(b) Selected medical supplies shall be available to program consumers for use in the consumer's home.

(c) Selected DME and medical supplies shall be considered for coverage only in cases where exceptional hardship or medical need has been justified by medical necessity documentation or granting of prior authorization.

(d) Orthotics and prosthetics shall be available to program consumers from orthotic and prosthetic dealers enrolled to participate as required by K.A.R. 30-5-59. The effective date of this regulation shall be May 1, 2001.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-84-26, Oct. 19, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended Jan. 2, 1989; amended July 1, 1989; amended May 1, 2001.

30-5-108a. Reimbursement for durable medical equipment, medical supplies, orthotics, and prosthetics.

(a) Reimbursement for covered services shall be made on the basis of rates established by the secretary.

(b) Reimbursement for used equipment or repairs of equipment shall not exceed 75% of the reimbursement rate for new equipment.

(c) This regulation shall be effective on and after December 31, 2002.

Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended Dec. 31, 2002.

30-5-150. Co-pay requirements for medikan program recipients.

(a) Medikan program recipients shall be obligated to the provider for co-payment amounts identical to the co-payment amounts for medicaid program recipients pursuant to K.A.R. 30-5-71.

Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended May 1, 1988.

30-5-151. Scope of hospital services for medikan program recipients. Hospital services for medikan program recipients shall be limited to services provided for the following conditions:

(a) Acute psychotic episodes;

(b) traumatic injury;

(c) burns; and

(d) substance abuse acute detoxification.

Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; ; effective, T-84-8, March 29, 1983; amended, T-84-11, July 1, 1983; effective May 1, 1984; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; revoked, T-30-12-28-89, Jan. 2, 1990; effective, T-30-2-28-90, Feb. 28, 1990; amended, T-30-6-10-91, July 1, 1991; amended Dec. 31, 1992; amended, T-30-2-15-93, Feb. 15, 1993; amended June 1, 1993.

30-5-152. Scope of rural health clinic services for medikan program recipients. The scope of rural health clinic services medikan program recipients shall be identical to the rural health clinic services pursuant to K.A.R. 30-5-82 covered for adult medicaid program recipients.

Authorized by and implementing K.S.A. 39-708c; effective, May 1, 1984; amended May 1, 1988.

30-5-153. Scope of physical therapist services.

(a) Physical therapist services shall be covered for medicaid/medikan beneficiaries when provided by a physical therapist who:

(1) is certified by medicare; and

(2) meets requirements listed in K.A.R. 100-35-1 through K.A.R. 100-35-7.

(b) The effective date of this regulation shall be December 29, 1995.

Authorized by and implementing K.S.A. 39-708c; effective Dec. 29, 1995.

30-5-155. Scope of Kan Be Healthy program services for medikan program recipients. Kan Be Healthy program services shall not be covered for medikan program recipients.

Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984; amended Jan. 2, 1989.

30-5-156. Scope of physician services for medikan program recipients. The scope of physician services for medikan program recipients shall be identical to the physician services pursuant to K.A.R. 30-5-88 covered for medicaid program recipients with the exception that outpatient psychotherapy for medikan recipients shall be limited to 24 hours per calendar year per recipient when provided by a physician, psychologist, community mental health center, or any combination of these providers.

Authorized by and implementing K.S.A. 39-708c; effective, T-84-8, March 29, 1983; amended, T-84-11, July 1, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988.

30-5-164. Scope of ambulance services for adult medikan program recipients. Coverage shall be limited to emergency transportation to a facility where medical services are rendered.

Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.

30-5-165. Scope of non-ambulance medical transportation services for adult medikan program recipients. Non-ambulance medical transportation services shall not be covered for adult medikan program recipients.

Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.

30-5-166. Scope of durable medical equipment, medical supplies, orthotic and prosthetic services for adult medikan program recipients. Coverage for durable medical equipment and medical supplies shall be limited to services necessary to support life.

Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective, T-84-8, April 1, 1983; effective May 1, 1984.

**AGENCY 30 DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ARTICLE 45. YOUTH SERVICES**

30-45-10. Definitions.

(a) "Medical neglect" includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.

(b) "Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by failing to provide treatment, which in the treating physician's reasonable medical judgment, is most likely to ameliorate or correct all life-threatening conditions, except when the treatment would be futile in terms of survival of the infant and the treatment itself under such circumstances would be inhumane. In all circumstances "withholding of medically indicated treatment" shall always include the failure to provide appropriate nutrition, hydration or medication.

(c) "Reasonable medical judgment" means a medical judgment made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

(d) "Infant" means an infant less than one year of age. The reference to less than one year of age shall not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age. The standards set forth in subsection (b) of this regulation should be consulted thoroughly in the evaluation of any issue of medical neglect involving an infant older than one year of age who has been continuously hospitalized since birth, whose birth was extremely premature, or who has a long-term disability.

(e) "Designated hospital liaison" means the individual designated by the hospital administrator as the person to be contacted by agency personnel upon a report of medically indicated treatment being withheld from a disabled infant. Names of liaisons shall be furnished to the agency annually by each hospital.

(f) "Hospital medical ethics review committee" means the group established by the hospital to review medical treatment and make recommendations to the appropriate medical personnel involved in the case.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22 1986; effective May 1, 1987.

30-45-11. Reports of medically neglected infants.

(a) Reports of medical neglect of a disabled infant shall be made to the local social and rehabilitation services office. Receipt of the report and subsequent initiation of an investigation will follow the emergency procedures established under the Kansas code for care of children. Upon receiving notification of withholding of medically indicated treatment from a disabled infant, an agency social worker shall:

(1) Contact the designated hospital liaison at the facility where the infant is located;

(2) contact the hospital medical ethics review committee at the facility housing the infant to obtain the committee's findings or the Kansas perinatal medical council if no hospital medical ethics review committee exists; and

(3) include as a part of the investigative report, information from and reports to the designated hospital liaison and the hospital medical ethics review committee or the Kansas perinatal medical council if no hospital medical ethics review committee exists.

(b) Subsequent to the initial investigation of a report of medical neglect of a disabled infant, the agency personnel shall follow the procedures established under the Kansas code for care of children and all due process rights contained therein shall apply.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.

30-45-12. Responsible reporters.

(a) Physicians, nurses, hospital administrators and others listed in K.S.A. 1985 Supp. 38-1522 shall be required to report cases of medical neglect of disabled infants.

(b) Reports to social and rehabilitation services of medical neglect of disabled infants can be initiated by any concerned citizen. The reporter will remain anonymous unless the reporter agrees to the use of the reporter's identity by the agency. The reporter is not liable to prosecution for reports made in good faith pursuant to K.S.A. 1985 Supp. 38-1525 and 38-1526.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.

30-45-13. Records. Records of medical neglect cases involving disabled infants shall be handled according to established agency procedures.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective May 1, 1987.

30-45-14. Public information. The medical community shall be annually informed of the need to report cases of alleged medical neglect of disabled infants pursuant to these regulations.

Authorized by and implementing K.S.A. 1985 Supp. 39-708c, K.S.A. 75-5321; effective, T-87-29, Oct. 22, 1986; effective May 1, 1987.

**AGENCY 40 INSURANCE DEPARTMENT
ARTICLE 4. ACCIDENT AND HEALTH INSURANCE**

40-4-41. Utilization review organizations; application; definitions.

(a) Except as provided in K.S.A. 40-22a06(b), and amendments thereto, each organization offering utilization review services that is required to apply for a certificate pursuant to K.S.A 40-22a01, et seq., and amendments thereto, shall comply with these regulations. Utilization review services subject to these regulations shall include the following:

(1) Prospective, concurrent, and retrospective utilization review for inpatient and outpatient care rendered by a health care provider; and

(2) utilization review activity conducted in connection with health benefit plans.

(b) Notwithstanding adherence to the standards prescribed by these regulations, the decision as to what treatment to prescribe for an individual patient shall remain that of the health care provider, and either the patient or the patient's

representative. The final decision as to whether the prescribed treatment constitutes a covered benefit shall be the responsibility of the claims administrator or health benefit plan.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Advisory board of osteopathic specialists (ABOS)" means the American osteopathic association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and the pattern of training.

(2) "American board of medical specialties (ABMS)" means the entity that was organized originally in 1933 as the advisory board of medical specialties, collaborated in 1970 with the American medical association (AMA), and is the recognized certifying agent for establishing and maintaining standards of medical specialization and the pattern of training.

(3) "Appeal" means a formal request to reconsider a determination not to certify an admission, extension of stay, or other health care service.

(4) "Appeals consideration" means clinical review conducted by appropriate clinical peers who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. This term is sometimes referred to as "third-level review."

(5) "Attending health care provider" means the health care provider who is selected by, or assigned to the patient and who has primary responsibility for the treatment and care of the patient as provided by the applicable licensing, registration, or certification requirements of Kansas.

(6) "Board-certified" means a label indicating that a physician has passed an examination given by a medical specialty board and has other eligibility requirements that certify the physician as a specialist in that area.

(7) "Case management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

(8) "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(9) "Claims administrator" means any entity that recommends or determines whether to pay claims to enrollees, health care providers, physicians, hospitals, or others on behalf of the health benefit plan. These payment determinations shall be made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

(10) "Clinical director" means a health professional who meets the following criteria:

(A) Is duly licensed or certified;

(B) is an employee of, or party to a contract with, a utilization review organization; and

(C) is responsible for clinical oversight of the utilization review program, including the credentialing of professional staff and quality assessment and improvement functions.

(11) "Clinical peer" means a physician or other health professional who holds an unrestricted license and is in the same or similar specialty as that which typically manages the medical condition, procedures, or treatment under review. As a peer in a similar specialty, the individual shall be in the same profession, which shall mean the same licensure category, as that of the ordering provider.

(12) "Clinical rationale" means a statement providing additional clarification of the clinical basis for a noncertification determination. The clinical rationale shall relate the noncertification to the patient's condition or treatment plan and shall supply a sufficient basis for a decision to pursue an appeal.

(13) "Clinical review criteria" means the written policies, screens, decision rules, medical protocols, or guidelines used by the utilization review organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

(14) "Concurrent review" means a utilization review conducted during a patient's inpatient stay or course of treatment and is sometimes called a "continued stay review."

(15) "Discharge planning" means the process that assesses a patient's needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

(16) "Enrollee" means an individual who participates in, and is covered by a health plan.

(17) "Expedited appeal" means a request by telephone for an additional review of a determination not to certify imminent or ongoing services that requires a review conducted by a clinical peer who was not involved in the original determination not to certify.

(18) "Facility rendering service" means the institution or organization in which the requested admission, procedure, or service is provided. These facilities may include the following:

(A) Hospitals and outpatient surgical facilities;

(B) individual practitioner offices;

(C) rehabilitation centers;

(D) residential treatment centers;

(E) skilled nursing facilities;

(F) laboratories; and

(G) imaging centers.

(19) "Health benefit plan" means any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

(A) "Health benefit plan" shall include the following:

(i) Any individual, group, or blanket policy of accident and sickness, medical, or surgical expense coverage; and

(ii) any provision of a policy, contract, plan, or agreement for medical service, including any contract of a health maintenance organization, nonprofit medical and hospital service corporation, or municipal group-funded sickness and accident pool.

(B) "Health benefit plan" shall not include any of the following:

(i) A policy or certificate covering only credit;

(ii) a policy or certificate covering only disability income;

- (iii) coverage issued as a supplement to liability insurance;
- (iv) insurance arising out of a workers compensation or similar law;
- (v) automobile medical payment insurance;
- (vi) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy;
- (vii) medicare; or
- (viii) medicaid.

(20) "Health care provider" shall have the meaning ascribed by K.S.A. 40-22a03(d) and amendments thereto.

(21) "Health professional" means an individual who meets the following criteria:

(A) Has undergone formal training in a health care field; and

(B) holds a state license or state certificate in a health care field.

(22) "Initial clinical review" means the clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but shall refer requests that do not meet clinical review criteria to peer clinical review for certification or noncertification. The term is sometimes referred to as "first-level review."

(23) "Inpatient care" means admissions to and services provided in all licensed medical care facilities and other licensed inpatient facilities, including skilled nursing facilities, residential treatment centers, and freestanding rehabilitation facilities.

(24) "License" means a license or permit to practice medicine or a health profession issued by any state or jurisdiction of the United States.

(25) "Medical director" means a doctor of medicine or doctor of osteopathic medicine who meets the following criteria:

(A) Is duly licensed to practice medicine;

(B) is an employee of, or a party to a contract with, a utilization review organization; and

(C) has responsibility for clinical oversight of the utilization review organization's utilization review, credentialing, quality management, and other clinical functions.

(26) "Nonclinical administrative staff" means staff who do not meet the definition of "health professional."

(27) "Ordering provider" means the specific physician or other provider who prescribed the health care service being reviewed.

(28) "Outpatient care" means health care provider diagnostic and therapeutic services provided at any medical care facility, and other outpatient locations, including laboratories, radiology facilities, provider offices, and patient homes.

(29) "Patient" means the enrollee or covered person who files a claim for benefits or for whom a claim for benefits has been filed.

- (30) "Peer clinical review" means clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during the initial clinical review. This term is sometimes referred to as "second-level review."
- (31) "Peer clinical reviewer" means a health care provider who holds a nonrestricted license in a state of the United States and who is in the same or similar profession as that which typically manages the health condition, procedure, or treatment under review.
- (32) "Principal reason" or "principal reasons" means a clinical or nonclinical statement describing the reason or reasons for the noncertification determination. "Lack of medical necessity" shall not be deemed sufficient to meet this definition.
- (33) "Prospective review" means any utilization review conducted before a patient's admission, stay, or other service or course of treatment and is sometimes called "precertification review."
- (34) "Provider" means a licensed health care facility, program, agency, or health professional that delivers health care services.
- (35) "Quality management program" means a structured program that, at a minimum, monitors and evaluates the quality and effectiveness of a utilization management organization's policies, progress, and practices and provides management intervention, as needed, to support compliance with these standards.
- (36) "Reconsideration" means a request by telephone or written notification for additional review of a utilization review determination not to certify, which shall be performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.
- (37) "Retrospective review" means a review of services provided after the discharge of the patient.
- (38) "Scripted clinical screening" is a process using scripted criteria by which trained personnel can perform a preliminary or continued standardized review or evaluation of medical care being provided or to be provided. If the scripted criteria are met, the medical services are authorized. If the scripted criteria are not met, the case is referred to a health professional for further review.
- (39) "Review of service request" means the review of information submitted to the utilization review organization for health care services that neither require medical necessity certification nor result in a noncertification decision.
- (40) "Second opinion" means the requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.
- (41) "Standard appeal" means a request to review a determination not to certify an admission, extension of stay, or other health care service, which shall be conducted by a peer clinical reviewer who was not involved in any previous non-certification pertaining to the same episode of care.
- (42) "Structured clinical data" means clinical information that is precise and permits exact matching against explicit medical terms, diagnoses, or procedure codes, or other explicit medical terms, diagnoses, or procedure codes, or other explicit choices, without the need for interpretation.
- (43) "Utilization management (UM)" shall have the same meaning as that ascribed to "utilization review (UR)," which is defined in K.S.A. 40-22a03(b) and amendments thereto.
- (44) "Utilization review (UR)" shall have the meaning ascribed by K.S.A. 40-22a03(b) and amendments thereto.
- (45) "Utilization review organization" shall have the meaning ascribed by K.S.A. 40-22a03(c) and amendments thereto.

(46) "Variance" means a deviation from a specific standard that can be supported by a federal or state law or regulation or by a contractual agreement and that the commissioner of insurance determines as sufficient to reflect the intent of K.S.A. 40-2201 et seq., and amendments thereto, these regulations, and the rights of the parties involved.

(47) "Written notification" means correspondence transmitted by mail, facsimile, or electronic medium.

Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

40-4-41a. Utilization review organizations; responsibility for requesting certification. If specified in the health benefit plan which imposes the utilization review requirements:

(a) The insured individual seeking the health care services shall be responsible for notifying the utilization review organization in a timely manner and initiating the request for certification of health care services; and

(b) any health care provider or responsible patient representative, including a family member, may assist in fulfilling the responsibility of initiating the request for certification.

Authorized by K.S.A. 40-103 and K.S.A. 1994 Supp. 40-22a01, et seq.; implementing K.S.A. 1994 Supp. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995.

40-4-41b. Utilization review organizations; requirements for collecting information. When conducting routine prospective, concurrent, and retrospective utilization reviews, each utilization review organization shall comply with the following requirements:

(a) Each utilization review organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, and frequency or duration of services. Utilization review organizations shall not perform any of the following:

(1) Routinely require health care providers to supply numerically codified diagnoses or procedures to be considered for certification. Utilization review organizations may ask for this coding since, if it is known, its inclusion in the data collected increases the effectiveness of the communication;

(2) routinely request copies of clinical records on all patients reviewed. During prospective and concurrent review, copies of clinical records shall be required only when a difficulty develops in certifying the necessity or appropriateness of the admission or extension of stay, or the frequency or duration of service. In those cases, only the necessary or pertinent sections of the record shall be required; or

(3) request a review of all records on all patients. This shall not preclude a request for copies of relevant clinical records retrospectively for clinical review for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or utilization review provisions. With the exception of reviewing records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records.

(b) Each utilization review organization shall accept required or requested information when submitted on claim forms as authorized by K.S.A. 40-2253, and amendments thereto, and K.A.R. 40-4-40.

(c) Each utilization review organization shall limit its data requirements to the following elements unless otherwise prescribed in these regulations:

- (1) Patient information, which shall include the patient's name, address, telephone number, date of birth, gender, social security number or patient identification number, the name of the carrier or plan, including the plan type, and plan identification number;
- (2) enrollee information, which shall include the enrollee's name, address, telephone number, social security number or employee identification number, relation to patient, employer, health benefit plan, group number or plan identification number, and other types of coverage available, including workers compensation, auto, tricare (formerly known as champus), medicare, or other coverage;
- (3) health care provider information, which shall include the provider's name, address, telephone number, degree, specialty or certification status, and tax identification or other identification number;
- (4) diagnosis or treatment information, which shall include the primary diagnosis, secondary diagnosis, tertiary diagnosis, multiaxial diagnosis, proposed or provided procedures or treatments, surgical assistant requirement, anesthesia requirement, admission or service dates, the procedure date, and the proposed length of stay;
- (5) clinical information sufficient to support the appropriateness and level of service proposed or provided, and the name of a contact person for detailed clinical information;
- (6) facility information, which shall include the following:
 - (A) The type of facility, including an inpatient or outpatient facility, special unit, skilled nursing facility, rehabilitation facility, office, or clinic;
 - (B) the licensing or certification status of the facility, including any applicable diagnostic-related group exempt status; and
 - (C) the facility's name, address, telephone number, and tax identification number or other identification number;
- (7) concurrent or continued stay review information, which shall include the following:
 - (A) The number of additional days, services, or procedures proposed;
 - (B) a description of the reasons for the extension, including clinical information sufficient to support the appropriateness and level of service proposed;
 - (C) information regarding the continued or changed diagnoses; and
 - (D) discharge planning;
- (8) information on admissions to facilities other than medical care facilities, which shall include a history of the present illness, the patient treatment plan and goals, the prognosis, staff qualifications, and 24-hour availability of appropriate staff;
- (9) additional information for specific review functions, which may include discharge planning or catastrophic case management or, when applicable, second opinion information sufficient to support benefit plan requirements; and
- (10) other additional information when there is a significant lack of agreement between the utilization review organization and health care provider regarding the appropriateness of certification. Significant lack of agreement shall mean that the utilization review organization meets the following conditions:

- (A) Has tentatively determined, through its professional staff, that a service cannot be certified;
- (B) has referred the case to a peer clinical reviewer for review; and
- (C) for prospective and concurrent review, has talked to or attempted to talk to the health care provider for further information.

(d) Each utilization review organization shall share all clinical and demographic information on individual patients among its various divisions to avoid duplicate requests for information from enrollees or providers.

(e) For prospective review and concurrent review, each utilization review organization shall base its review determinations solely on the medical information obtained by the utilization review organization at the time of the review determination.

(f) For retrospective review, each utilization review organization shall base its review determinations solely on the medical information available to the attending health care provider or ordering provider at the time the medical care was provided.

(g) Each utilization review organization shall reverse its certification determination only if information provided to the utilization review organization is materially different from that which was reasonably available at the time of the original determination.

Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

40-4-41c. Utilization review organizations; written procedures. Each utilization review organization shall maintain the following written procedures:

(a) Written procedures to assure that reviews and second opinions are conducted in a timely manner shall be maintained as follows:

(1) Each utilization review organization shall make prospective or concurrent certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the health care provider or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

(2) The utilization review organization may review ongoing inpatient stays, but shall not routinely conduct a daily review of all these stays. The frequency of the review for extension of the initial determination may vary, based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(3) Each utilization review organization shall make retrospective determinations, in the absence of any contractual agreement, within 30 days of the receipt of the necessary information.

(b) Each utilization review organization shall maintain written procedures for providing notification of determinations regarding all forms of certification in accordance with the following:

(1) When an initial determination is made to certify, the utilization review organization shall notify the attending health care provider or other ordering provider, facility rendering service, and enrollee or patient promptly in writing, by telephone, or by electronic transmission.

(2) The utilization review organization shall transmit each determination to certify an extended stay or additional services resulting from a concurrent review to the attending health care provider or other ordering provider and the facility rendering services by telephone, by electronic

transmission, or in writing. The determination shall be transmitted within one working day of receipt of all information necessary to complete the review process, but not later than the end of a current certified period.

(3) If a utilization review organization transmits written confirmation of certification for continued hospitalization or services, that notification shall include, when possible, the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or onset of services.

(4) When a prospective or concurrent review determination is made not to certify an admission or extension of an inpatient stay, course of treatment, or other service requiring a review determination, the decision shall be made by a peer clinical reviewer only after not less than two bona fide attempts have been made to contact and consult with the attending health care provider.

(A) If the attending health care provider cannot be contacted in a timely manner, the utilization review organization shall send written notification to the attending health care provider or ordering provider and the enrollee or patient within one working day following the determination. Each notification shall be accompanied by the most appropriate telephone number necessary to facilitate an expedited appeal.

(i) The utilization review organization shall provide within one business day of receipt of the request the opportunity for the attending health care provider or other ordering provider to discuss the noncertification decision with a clinical peer reviewer, if the original peer reviewer cannot be available within one business day.

(ii) If a reconsideration or peer-to-peer conversation does not resolve a difference of opinion, the utilization review organization shall, at the time of the conversation, inform the attending health care provider or other ordering provider of the right to initiate an expedited appeal or standard appeal and the procedure to do so.

(B) The written notification shall include the principal reasons for the determination and procedures to initiate an appeal of the determination. A determination not to certify may be based on a lack of adequate information to certify after a reasonable attempt has been made to contact the health care provider.

(C) Each of the letters to the provider, patient, and facility shall include a statement that the clinical rationale used in making the noncertification decision shall be provided in writing upon request.

(D) Upon request, the utilization review organization shall provide the clinical rationale in writing to the provider, patient, or facility rendering service.

(5) When a retrospective determination is made not to certify an admission, stay, or other service, the decision shall be made only by a peer clinical reviewer. The utilization review organization shall provide written notification of the determination to attending health care provider or other ordering provider, patient, and hospital or facility rendering services. The written notification shall include the principal reasons for the determination and procedures to initiate a standard appeal of the determination. The notification shall include a statement that the clinical rationale used in making the determination will be provided in writing upon request. A determination not to certify may be based on a lack of adequate information to certify after a reasonable attempt has been made to contact the health care provider.

(c) Each utilization review organization shall maintain written procedures to address the failure or inability of a health care provider, patient, or other representative to provide the necessary information for review. If

the patient or provider will not release the necessary, clinically relevant information to the utilization review organization, the utilization review organization may administratively deny certification in accordance with its own policy or that of the health benefit plan.

Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended May 16, 1997; amended June 22, 2001.

40-4-41d. Utilization review organizations; appeal procedures. Each utilization review organization shall have in place procedures for appeals of a determination not to certify an admission, procedure, service, or extension of stay. The right to appeal shall be available to the patient or enrollee, the representative of the patient or enrollee, and the attending health care provider, other ordering provider, or facility rendering service on behalf of the patient. Hospitals or other health care providers may assist in an appeal. The procedures for appeals shall include, at a minimum, the following:

(a) Expedited appeal.

(1) When an initial determination not to certify a health care service is made before or during an ongoing service requiring review, and the attending health care provider or other ordering provider believes that the determination warrants immediate appeal, the attending health care provider or other ordering provider shall have an opportunity to appeal that determination over the telephone or via facsimile on an expedited basis.

(2) Each utilization review organization shall provide reasonable access to a peer clinical reviewer, not to exceed one working day, by telephone or in person to discuss the determination with the attending health care provider or other ordering providers. The peer clinical reviewer shall be available for these appeals during normal business hours.

(3) The peer clinical reviewer shall have immediate access to the material that formed the basis for the original determination when discussing an appeal.

(4) The utilization review organization shall not be required to provide a peer clinical reviewer other than the peer clinical reviewer who made the original decision if the attending health care provider or other ordering provider only needs to supply additional or new information that will justify the need for the health care service or treatment.

(5) Health care providers and utilization review organizations shall attempt to share the maximum amount of information by telephone, facsimile, or other means to resolve the expedited appeal satisfactorily.

(6) The utilization review organization shall notify the attending health care provider or the ordering provider of its decision regarding the expedited appeal by telephone at the time the decision is made and shall notify either the attending health care provider or other ordering provider and the enrollee in writing within one working day.

(7) Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard appeal process.

(8) Noncertifications made on a retrospective basis may be appealed only through the standard appeal process.

(b) Standard appeal. The utilization review organization shall establish procedures for appeals to be made either in writing or by telephone.

- (1) Each utilization review organization shall notify in writing the enrollee or patient, attending health care provider or other ordering provider, and claims administrator of its determination on the appeal as soon as practical, but never later than 30 days, in the absence of any contractual agreement, after receiving the required documentation for the appeal.
- (2) The documentation required by the utilization review organization may include copies of part or all of the clinical record or a written statement from the attending health care provider or other ordering provider.
- (3) Before upholding the original decision not to certify for clinical reasons, a peer clinical reviewer who did not make the original noncertification determination shall review the documentation.
- (4) The process established by a utilization review organization may include a period within which an appeal shall be filed to be considered.
- (5) Each attending health care provider or other ordering provider who unsuccessfully appeals a determination not to certify shall be provided the clinical basis for that determination in writing, upon request.
- (6) In cases involving physician-directed services in which an appeal to reverse a determination not to certify for medical reasons is unsuccessful, the utilization review organization shall assure that a peer clinical reviewer, in the same or a similar medical specialty as that of the attending health care provider or other ordering provider, is reasonably available to review the case as mutually deemed appropriate.
- (7) In cases involving other than physician-directed services in which an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the utilization review organization shall assure that a peer clinical reviewer, in the same or similar profession as that of the attending health care provider or other ordering provider, is reasonably available to review the case as mutually deemed appropriate.
- (8) Each utilization review organization shall forward, by written notification, a certification or a determination not to certify to the enrollee or patient, attending health care provider or other ordering provider, and claims administrator for the health benefit plan.
- (9) The utilization review organization shall conduct appeals considerations by requiring health professionals who serve as clinical peers and who consider appeals to meet the following conditions:
 - (A) Hold a current active, unrestricted license to practice medicine or a health profession;
 - (B) for services provided by a physician, medical doctor, or doctor of osteopathic medicine, be board-certified by either of the following:
 - (i) A specialty board approved by the American board of medical specialties, for doctors of medicine; or
 - (ii) the advisory board of osteopathic specialists from the major areas of clinical services, for doctors of osteopathic medicine;
 - (C) for services provided by a nonmedical doctor or doctor of osteopathic medicine, be in the same profession and in a similar specialty as that which typically manages the medical condition, procedure, or treatment mutually deemed appropriate; and
 - (D) be oriented to the principles and procedures of utilization review and peer review.

Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

40-4-41e. Utilization review organizations; staff requirements. Each utilization review organization shall have utilization review staff who are properly trained, qualified, supervised, and supported by written, clinically substantiated criteria and review procedures.

- (a) (1) For data collection, intake screening, and scripted clinical screening, the use of nonclinical administrative staff shall be limited to the following:
 - (A) The performance of "review of service requirements";
 - (B) the collection and transfer of nonclinical data;
 - (C) the acquisition of structured clinical data; and
 - (D) any scripted clinical screening that does not require evaluation or interpretation of clinical information.
- (2) Nonclinical administrative staff performing the functions listed in paragraph (a)(1)(A) through (D) shall meet the following conditions:
 - (A) Be qualified and trained to perform "review of service requests";
 - (B) be supported by explicit instructions and scripts;
 - (C) be trained in the principles and procedures of the collection and transfer of nonclinical data, the acquisition of structured clinical data, scripted clinical screening, and the maintenance of confidentiality of patient-specific information;
 - (D) through an established process, promptly transfer a telephone call for review of services to an initial clinical reviewer if the review cannot be completed based on a formal script; and
 - (E) be monitored by a licensed health professional while performing administrative review.
- (b) The utilization review organization, when conducting initial clinical review, shall perform the following:
 - (1) Refer review of services that do not meet initial review criteria to peer clinical review;
 - (2) restrict the performance of the initial clinical review to individuals who meet both of the following requirements:
 - (A) Are health professionals; and
 - (B) possess a current and valid professional license or certificate in the state or states in which they work. If the state in which they work does not require professional licensure, each of the individuals shall possess a current and valid professional license or certificate in another state or shall be certified by the national accrediting body appropriate to each individual's profession;
 - (3) require initial clinical reviewers to be trained in the principles and procedures of utilization review; and

(4) require initial clinical reviewers to be supported by a doctor of osteopathic medicine or a clinical director who has an unrestricted license to practice medicine.

(c) (1) The utilization review organization shall conduct peer clinical reviews for all cases in which a clinical determination to certify cannot be made by initial clinical review. Peer clinical reviews shall be conducted by health professionals who meet the following criteria:

(A) Directly support the utilization review activity;

(B) are oriented in the principles and procedures of utilization management and peer review;

(C) are qualified to render a clinical opinion about the medical condition, procedures, and treatment under review; and

(D) meet one of the following criteria:

(i) Hold a current, unrestricted license in the same licensure category as that of the attending health care provider or other ordering provider; or

(ii) for standard appeals, are in active practice.

(2) The utilization review organization shall have a medical director or clinical director with professional postresidency experience in direct patient care who meets one of the following criteria:

(A) Holds an unrestricted license to practice medicine; or

(B) has a clinical specialty appropriate to the type of single service utilization management conducted.

Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

40-4-41f. Utilization review organizations; review requirements.

(a) Each utilization review organization shall use written, clinically substantiated criteria, as needed, for the purpose of determining or screening the appropriateness of the certification.

(1) This criteria shall be periodically evaluated and updated, and shall be made available to the attending health care provider or other ordering provider upon request.

(2) Professionally accepted review criteria shall be used for concurrent reviews and shall be periodically evaluated and updated.

(3) When copyright laws prohibit the copying of criteria for health care providers, the utilization review organization shall identify the type of criteria being utilized so that the health care provider may purchase the criteria directly from the source.

(4) Clinical protocols, as well as other relevant review processes used in a health benefit plan's concurrent review program, shall be established with appropriate involvement from health care provider panels made up of health care providers contracting with the utilization review organization.

(b) Each utilization review organization shall use one or more health care provider consultants, including, as needed and available, one or more specialists who are board-certified and working toward certification in a specialty board

approved by the American board of medical specialists or the American board of osteopathy from the major areas of clinical services.

(c) Each utilization review organization shall use one or more peer clinical reviewers who meet the following criteria:

- (1) Have a firm understanding of clinical practice;
- (2) are familiar with current treatment guidelines;
- (3) are able to access expert clinical opinions when necessary; and
- (4) take into consideration any local specific issues as described by the attending health care provider.

(d) Each utilization review organization shall provide a formal program for orientation and training of utilization review staff and professional consultants.

(e) Each utilization review organization shall maintain written documentation of an active quality management program that promotes objective and systematic monitoring and evaluation of utilization review processes and services.

(f) The utilization review organization shall, as part of its quality management program, include a written plan addressing the following:

- (1) Scope and objectives;
- (2) program organization;
- (3) monitoring and oversight mechanisms; and
- (4) evaluation and organizational improvement of clinical review activities.

(g) The utilization review organization shall, as part of its UR quality review program, provide written documentation that verifies the ongoing monitoring for compliance with this regulation, including the following:

- (1) Objectives and approaches utilized in the monitoring and evaluation of clinical review activities, including the systematic evaluation of complaints for patterns or trends;
- (2) the implementation of action plans to improve or correct identified problems; and
- (3) the mechanisms to communicate the results of the action plans to utilization review staff.

Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

40-4-41g. Utilization review organizations; access to review staff.

(a) Each utilization review organization shall provide access to its review staff by a toll-free or collect call telephone line, at a minimum, from 9:00 a.m. to 4:00 p.m. of each normal working day in the central time zone. Each utilization review organization shall also have a mechanism to receive timely callbacks from health care providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

(b) Each utilization review organization and its staff shall conduct its telephone reviews, on-site information gathering reviews, and health care provider communications during reasonable and normal business hours for health care providers, unless otherwise mutually agreed.

(c) Utilization review organization staff members shall identify themselves by name and by the name of their organization, and for on-site reviews, shall carry photograph identification and their organization's company identification card. On-site concurrent reviews shall, whenever possible, be scheduled at least one business day in advance of the appropriate health care provider contact. If requested by a health care provider or inpatient facility, the utilization review organization shall assure that its on-site review staff register with the appropriate contact person, if available, before requesting any clinical information or assistance from health care provider staff, and the on-site review staff shall wear appropriate hospital-supplied identification while on the premises.

(d) Each utilization review organization and its staff shall agree, if so requested, that the clinical records remain available in designated areas during the on-site review and that reasonable health care provider administrative procedures be followed by on-site review staff so as to not disrupt health care provider operations or patient care. These procedures, however, shall not limit the ability of a utilization review organization to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

(e) Upon request, each utilization review organization shall perform the following:

(1) Verbally inform patients, designated health care provider facility personnel, and any other ordering provider of the utilization review requirements and the general type of criteria used by the review agent; and

(2) verbally inform patients, hospitals, physicians, and other health professionals of its operational review procedures.

Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.

**AGENCY 51 DEPARTMENT OF HUMAN RESOURCES--DIVISION OF WORKERS COMPENSATION
ARTICLE 9. MEDICAL AND HOSPITAL**

51-9-10. Medical bills, reports, and treatment.

(a) Upon the completion of treatment in all compensation cases, physicians shall promptly notify the employer or carrier, and shall render their final bills forthwith. Bills for medical care providers and hospitals shall be itemized showing the date and the charge for services rendered. Separate bills should be presented to the employer or carrier by each surgeon, assistant, anesthetist, consultant, hospital, or nurse. In cases requiring prolonged treatment, physicians should submit partial bills, fully itemized, at intervals of at least 60 days.

(b) (1) Medical reports of the physician should be submitted on a periodic basis depending upon the nature and severity of the injuries involved and, in all cases, immediately upon request of the respondent or insurance carrier. A report shall be rendered on the date on which the physician releases the worker to return to work and forwarded to the employer or insurance carrier and to the employee, if requested.

(2) In cases of amputation, the physician shall mark the exact point of amputation on a diagram showing the member involved.

(3) The patient privilege preventing the furnishing of medical information by doctors and hospitals is waived by a worker seeking workers compensation benefits, and all reports, records, or other data concerning examinations or treatment shall be furnished to the employer or insurance carrier or the director that individual's request without the necessity of a release by the worker.

(4) Unreasonable refusal by the worker to cooperate with the employer or insurance carrier or the director by failing to furnish medical information releases for the worker's medical history may result in compensation being denied or terminated after hearing before the director.

(5) The employee shall immediately be furnished a copy of any medical report that authorizes return to work.

(c) Nurses, whether registered or practical, shall be furnished in an institution or the worker's home when the treating doctor recommends this nursing care. Nursing service by a member of the worker's family shall be provided if approved in advance by the treating physician.

Authorized by K.S.A. 1996 Supp. 44-510, as amended by L. 1997, Ch. 125, Sec. 4 and K.S.A. 44-573; effective Jan. 1, 1966; amended Jan. 1, 1969; amended Jan. 1, 1971; amended Jan. 1, 1973; amended, E-74-31, July 1, 1974; amended May 1, 1975; amended, E-76-23, May 30, 1975; amended Feb. 15, 1977; amended May 1, 1978; amended May 22, 1998.

AGENCY 60 KANSAS STATE BOARD OF NURSING
ARTICLE 3. REQUIREMENTS FOR LICENSURE AND STANDARDS OF PRACTICE

60-3-109a. Standards of practice.

(a) Each registered professional nurse shall be familiar with the Kansas nurse practice act, the standards of practice of the profession and the code of ethics for professional nurses.

(b) Each licensed practical nurse shall be familiar with the Kansas nurse practice act, the standards of practice and the code of ethics for practical nurses.

Authorized by K.S.A. 65-1113; implementing K.S.A. 74-1106; effective May 1, 1985.

60-3-110. Unprofessional conduct. Any of the following shall constitute "unprofessional conduct":

(a) Performing acts beyond the authorized scope of the level of nursing for which the individual is licensed;

(b) assuming duties and responsibilities within the practice of nursing without making or obtaining adequate preparation or maintaining competency;

(c) failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard each patient;

(d) inaccurately recording, falsifying, or altering any record of a patient or agency or of the board;

(e) physical abuse, which shall be defined as any act or failure to act performed intentionally or carelessly that causes or is likely to cause harm to a patient. This term may include any of the following:

(1) The unreasonable use of any physical restraint, isolation, or medication that harms or is likely to harm a patient;

(2) the unreasonable use of any physical or chemical restraint, medication, or isolation as punishment, for convenience, in conflict with a physician's order or a policy and procedure of the facility or a state statute or regulation, or as a substitute for treatment, unless the use of the restraint, medication, or isolation is in furtherance of the health and safety of the patient;

(3) any threat, menacing conduct, or other nontherapeutic or inappropriate action that results in or might reasonably be expected to result in a patient's unnecessary fear or emotional or mental distress; or

(4) failure or omission to provide any goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm;

(f) commission of any act of sexual abuse, sexual misconduct, or sexual exploitation related to the licensee's practice;

- (g) verbal abuse, which shall be defined as any word or phrase spoken inappropriately to or in the presence of a patient that results in or might reasonably be expected to result in the patient's unnecessary fear, emotional distress, or mental distress;
- (h) delegating any activity that requires the unique skill and substantial specialized knowledge derived from the biological, physical, and behavioral sciences and judgment of the nurse to an unlicensed individual in violation of the Kansas nurse practice act or to the detriment of patient safety;
- (i) assigning the practice of nursing to a licensed individual in violation of the Kansas nurse practice act or to the detriment of patient safety;
- (j) violating the confidentiality of information or knowledge concerning any patient;
- (k) willfully or negligently failing to take appropriate action to safeguard a patient or the public from incompetent practice performed by a registered professional nurse or a licensed practical nurse. "Appropriate action" may include reporting to the board of nursing;
- (l) leaving an assignment that has been accepted, without notifying the appropriate authority and allowing reasonable time for replacement;
- (m) engaging in conduct related to licensed nursing practice that is likely to deceive, defraud, or harm the public;
- (n) diverting drugs, supplies, or property of any patient or agency;
- (o) exploitation, which shall be defined as misappropriating a patient's property or taking unfair advantage of a patient's physical or financial resources for the licensee's or another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false pretense, or false representation;
- (p) solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee;
- (q) advertising nursing superiority or advertising the performance of nursing services in a superior manner;
- (r) failing to comply with any disciplinary order of the board;
- (s) failing to complete the requirements of the impaired provider program of the board;
- (t) failing to furnish the board, its investigators, or its representatives with any information legally requested by the board;
- (u) engaging in nursing practice while using a false or assumed name or while impersonating another person licensed by the board;
- (v) practicing without a license or while the license has lapsed;
- (w) allowing another person to use the licensee's license to practice nursing; or
- (x) knowingly aiding or abetting another in any act that is a violation of any healthcare licensing act.

Authorized by K.S.A. 65-1129; implementing K.S.A. 2001 Supp. 65-1120; effective May 1, 1982; amended Sept. 27, 1993; amended Sept. 6, 1994; amended Oct. 25, 2002.

AGENCY 60 KANSAS STATE BOARD OF NURSING
ARTICLE 11. ADVANCED REGISTERED NURSE PRACTITIONERS

60-11-101. Definition of advanced role; limitations; restrictions.

(a) An advanced registered nurse practitioner, as defined by K.S.A. 65-1113, and amendments thereto, shall function in an expanded role to provide primary health care to individuals, families, or groups, or some combination of these groups of clients, in a variety of settings, including homes, institutions, offices, industries, schools, community agencies, and private practice. Advanced registered nurse practitioners shall function in a collegial relationship with physicians and other health professionals in the delivery of primary health care services. Advanced registered nurse practitioners shall be authorized to make independent decisions about nursing needs of families and clients, and interdependent decisions with physicians in carrying out health regimens for families and clients. Advanced registered nurse practitioners shall be directly accountable and responsible to the consumer.

(b) "Primary health care" means the prevention of disease, promotion and maintenance of health, assessment of needs, long-term nursing management of chronic illness, and referral of clients to other resources. The contact between advanced registered nurse practitioner and client may be for an episode of illness, or it may be for continuous health care monitoring.

(c) The physical presence of the physician shall not necessarily be required when care is given by the advanced registered nurse practitioner.

(d) "Prescription order" shall have the meaning set forth in K.S.A. 65-1626, and amendments thereto.

(e) "Prescription" shall have the meaning set forth in K.S.A. 65-1626, and amendments thereto.

Authorized by and implementing K.S.A. 65-1113 and K.S.A. 1999 Supp. 65-1130; effective May 1, 1984; amended March 31, 2000.

60-11-102. Categories of advanced registered nurse practitioners. The four categories of advanced registered nurse practitioners certified by the board of nursing are:

- (a) nurse clinician or nurse practitioner;
- (b) nurse anesthetist;
- (c) nurse-midwife; and
- (d) clinical specialist.

Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984.

60-11-103. Qualifications of advanced registered nurse practitioners.

(a) To be certified as an advanced registered nurse practitioner in any of the categories of advanced practice, as identified in K.A.R. 60-11-102, each applicant shall meet at least one of the following criteria:

- (1) Complete a formal, post-basic nursing education program located or offered in Kansas that has been approved by the board and prepares the nurse to function in the advanced role for which application is made;
- (2) complete a formal, post-basic nursing education program that is not located or offered in Kansas but is determined by the board to meet the standards for program approval established by K.A.R. 60-11-108;

(3) have completed a formal, post-basic nursing education program that may be no longer in existence but is determined by the board to meet standards at least as stringent as those required for program approval by the board at the time of graduation;

(4) hold a current certificate of authority to practice as an advanced registered nurse practitioner in the category for which application is made and that meets the following criteria:

(A) Was issued by another board of nursing; and

(B) required completion of a program meeting standards equal to or greater than those established by K.A.R. 60-11-108; or

(5) complete a formal educational program of post-basic study and clinical experience that can be demonstrated by the applicant to have sufficiently prepared the applicant for practice in the category of advanced practice for which application is made. The applicant shall show that the curriculum of the program is consistent with public health and safety policy and that it prepared individuals to perform acts generally recognized by the nursing profession as capable of being performed by persons with post-basic education in nursing.

(b) Each applicant for certification as an advanced registered nurse practitioner in a category other than anesthesia or midwifery shall meet one of the following requirements:

(1) Have met one of the requirements of subsection (a) of this regulation before July 1, 1994;

(2) if none of the requirements in subsection (a) of this regulation have been met before July 1, 1994, meet one of the requirements of subsection (a) of this regulation and hold a baccalaureate or higher degree in nursing; or

(3) if none of the requirements in subsection (a) of this regulation are met before July 1, 2002, meet one of the requirements of subsection (a) of this regulation and hold a master's or higher degree in a clinical area of nursing.

(c) Each applicant for certification as an advanced registered nurse practitioner in the category of anesthesia shall meet one of the following requirements:

(1) Meet one of the requirements of subsection (a) of this regulation before July 1, 2002; or

(2) if none of the requirements in subsection (a) of this regulation are met before July 1, 2002, meet one of the requirements of subsection (a) of this regulation and hold a master's degree.

(d) Each applicant for certification as an advanced registered nurse practitioner in the category of midwifery shall meet one of the following requirements:

(1) Meet one of the requirements of subsection (a) of this regulation before July 1, 2000; or

(2) if none of the requirements in subsection (a) of this regulation are met before July 1, 2000, meet one of the requirements of subsection (a) of this regulation and hold a baccalaureate degree in nursing.

(e) Certification may be granted if an individual has been certified by a national nursing organization whose certification standards have been approved by the board as equal to or greater than the corresponding standards established by the board for obtaining certification to practice as an advanced registered nurse practitioner. National nursing organizations with certification standards that meet this standard shall be identified by the board, and a current list of national nursing organizations with certification standards approved by the board shall be maintained by the board. Any licensee may request that a certification program be considered by the board for approval and, if approved, included by the board on its list of national nursing organization approved certification standards.

(f) Each applicant who completes an advanced registered nurse practitioner program after January 1, 1997 shall have completed three college hours in advanced pharmacology or the equivalent.

(g) Each applicant who completes an advanced registered nurse practitioner program after January 1, 2001 in a category other than anesthesia or midwifery shall have completed three college hours in advanced pathophysiology or its equivalent and three college hours in advanced health assessment or its equivalent.

(h) Refresher course. Notwithstanding the provisions of subsections (a) through (f), any applicant for a certificate to practice as an advanced registered nurse practitioner who has not gained 1,000 hours of advanced nursing practice during the five years preceding application shall be required to successfully complete a refresher course as defined by the board.

Authorized by and implementing K.S.A. 65-1130, as amended by L. 1999, Ch. 115, § 1; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985; amended, T-60-11-14-90, Nov. 14, 1990; amended, T-60-3-14-91, March 14, 1991; amended Sept. 2, 1991; amended March 9, 1992; amended Sept. 14, 1992; amended April 26, 1993; amended Sept. 6, 1994; amended Jan. 3, 1997; amended March 31, 2000.

60-11-104. Functions of the advanced registered nurse practitioner, nurse clinician or nurse practitioner.

Advanced registered nurse practitioners function in the expanded role of nurse clinician or nurse practitioner, at a specialized level, through the application of advance knowledge and skills. Each nurse clinician or nurse practitioner shall be authorized to:

- (a) Perform all functions defined for basic nursing practice;
- (b) evaluate the physical and psychosocial health status of the client through a comprehensive health history and physical examination, using skills of observation, inspection, palpation, percussion and auscultation, and using diagnostic instruments or laboratory procedures that are basic to the screening of physical signs and symptoms;
- (c) assess normal and abnormal findings from the history, physical examination and laboratory reports;
- (d) plan, implement and evaluate care;
- (e) consult with the client and members of the health care team to provide for acute and ongoing health care or referral of the client;
- (f) manage the medical plan of care prescribed for the client, based on protocols or guidelines adopted jointly by the nurse practitioner and the attending physician;
- (g) initiate and maintain accurate records, appropriate legal documents and other health and nursing care reports;
- (h) develop individualized teaching plans with the client based on overt and covert health needs;
- (i) counsel individuals, families and groups about health and illness and promote health maintenance;
- (j) recognize, develop and implement professional and community educational programs related to health care;
- (k) participate in periodic and joint evaluation of services rendered, including, but not limited to, chart reviews, patient evaluations and outcome of case statistics; and
- (l) participate, when appropriate, in the joint review and revision of adopted protocols or guidelines when the advanced registered nurse practitioner is involved in the medical plan of care.

Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.

60-11-104a. Protocol requirements; prescription orders.

(a) Each written protocol that an advanced registered nurse practitioner is to follow when prescribing, administering, or supplying a prescription-only drug shall meet the following requirements:

(1) Specify for each classification of disease or injury the corresponding class of drugs that the advanced registered nurse practitioner is permitted to prescribe;

(2) be maintained in either a loose-leaf notebook or a book of published protocols. The notebook or book of published protocols shall include a cover page containing the following data:

(A) The names, telephone numbers, and signatures of the advanced registered nurse practitioner and a responsible physician who has authorized the protocol; and

(B) the date on which the protocol was adopted or last reviewed; and

(3) be kept at the advanced registered nurse practitioner's principal place of practice.

(b) Each advanced registered nurse practitioner shall ensure that each protocol is reviewed by the advanced registered nurse practitioner and physician at least annually.

(c) Each prescription order in written form shall meet the following requirements:

(1) Include the name, address, and telephone number of the practice location of the advanced registered nurse practitioner;

(2) include the name, address, and telephone number of the responsible physician;

(3) be signed by the advanced registered nurse practitioner with the letters A.R.N.P.;

(4) be from a class of drugs prescribed pursuant to protocol; and

(5) contain any D.E.A. registration number issued to the advanced registered nurse practitioner when a controlled substance, as defined in K.S.A. 65-4101(e) and amendments thereto, is prescribed.

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse or advanced registered nurse practitioner from conveying a prescription order orally or administering a drug if acting under the lawful direction of a person licensed to practice either medicine and surgery or dentistry, or certified as an advanced registered nurse practitioner.

(e) When used in this regulation, terms shall be construed to have the meanings set forth in the pharmacy act of the state of Kansas, K.S.A. 65-1626, and amendments thereto.

Authorized by and implementing K.S.A. 1999 Supp. 65-1130; effective, T-60-9-12-88, Sept. 12, 1988; effective Feb. 13, 1989; amended May 7, 1990; amended Jan. 3, 1995; amended March 31, 2000.

60-11-105. Functions of the advanced registered nurse practitioner; nurse-midwife. An advanced registered nurse practitioner functioning in the expanded role of nurse-midwife shall perform in an interdependent role as a member of a physician-directed health care team, within the framework of mutually adopted protocols or guidelines. Each nurse-midwife shall be authorized to:

- (a) Be responsible for the management and complete health care of the normal expanding family throughout pregnancy, labor, delivery, and post-delivery care;
- (b) participate in individual and group counseling and teaching throughout the childbearing cycle;
- (c) participate in well-woman gynecological procedures;
- (d) participate in periodic and joint evaluation of services rendered, including chart reviews, case reviews, patient evaluations, and outcome of case statistics; and
- (e) participate in the joint review and revision of adopted protocols or guidelines.

Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.

60-11-106. Functions of the advanced registered nurse practitioner; nurse anesthetist. The functions that may be performed by any advanced registered nurse practitioner functioning in the expanded role of registered nurse anesthetist shall be those functions defined in K.S.A. 65-1158, and amendments thereto.

Authorized by and implementing K.S.A. 65-1113, 65-1130, as amended by L. 1999, ch. 115, § 1; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985; amended March 31, 2000.

60-11-107. Functions of the advanced registered nurse practitioner; clinical nurse specialist. The primary responsibility of the advanced registered nurse practitioner performing in the expanded role of clinical nurse specialist shall be patient care delivery to a select population in a specialty area. Each clinical nurse specialist shall be authorized to:

- (a) Provide direct nursing care utilizing a broad base of advanced scientific knowledge, nursing theory and skills in assessing, planning, implementing, and evaluating those aspects of health and nursing care of individuals who require this specialized competence;
- (b) provide indirect nursing care. Each clinical nurse specialist shall plan, guide, evaluate and direct the nursing care given by other personnel associated with the nursing functions;
- (c) conduct nursing research. Each clinical nurse specialist shall create and test methods of nursing intervention and health care in the area of specialization;
- (d) teach and counsel individuals or groups. Each clinical nurse specialist shall utilize theories and skills of communication and teaching learning process to increase the knowledge or functioning of individuals and groups, nursing personnel, students and other members of the health care team;
- (e) serve as a consultant, and as a resource, utilizing advanced health knowledge and skills, to those who are directly and indirectly involved in patient care; and
- (f) participate in periodic evaluation of services rendered, including, but not limited to, chart reviews, case reviews, patient evaluations, and outcome of case statistics.

Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.

AGENCY 60 KANSAS STATE BOARD OF NURSING
ARTICLE 16. INTRAVENOUS FLUID THERAPY FOR LICENSED PRACTICAL NURSE

60-16-101. Definitions.

- (a) "Administration of intravenous fluid therapy" means utilization of the nursing process to deliver the therapeutic infusion or injection of substances through the venous system.
- (b) "Admixing" means the addition of a diluent to a medication or a medication to an intravenous solution.
- (c) "Calculating" means the mathematical determination of the flow rate and medication dosages.
- (d) "Competency examination" means a written examination and demonstration of mastery of clinical components of intravenous fluid therapy.
- (e) "Discontinuing" means stopping the intravenous flow or removing the intravenous access device, or both, based on an authorized order or nursing assessment.
- (f) "Evaluating" means ongoing analysis of the monitored patient response to the prescribed intravenous therapy for determination of the appropriate patient outcomes.
- (g) "Initiating" means the starting of intravenous therapy based on an authorized order by a licensed individual. Initiating shall include the following:
- (1) The patient assessment;
 - (2) selection and preparation of materials;
 - (3) calculation; and
 - (4) insertion and stabilization of the cannula.
- (h) "Intravenous push" means direct injection of medication into the venous circulation.
- (i) "Maintaining" means adjusting the control device for continuance of the prescribed intravenous therapy administration rate.
- (j) "Monitoring" means the ongoing assessment, observation, and communication of each patient's response to prescribed intravenous therapy. The infusion equipment, site, and flow rate shall be included in the monitoring process.
- (k) "Titration of medication" means an adjustment of the dosage of a medication to the amount required to bring about a given reaction in the individual receiving the medication.

Authorized by and implementing K.S.A. 2001 Supp. 65-1136; effective Nov. 21, 1994; amended June 12, 1998; amended Oct. 29, 1999; amended June 14, 2002.

60-16-102. Scope of practice for licensed practical nurse performing intravenous fluid therapy.

- (a) A licensed practical nurse under the supervision of a registered professional nurse may engage in a limited scope of intravenous fluid treatment, including the following:
- (1) Monitoring;
 - (2) maintaining;

(3) discontinuing intravenous flow and an intravenous access device not exceeding three inches in length in peripheral sites only; and

(4) changing dressings for intravenous access devices not exceeding three inches in length in peripheral sites only.

(b) Any licensed practical nurse who has met one of the requirements under K.S.A. 65-1136, and amendments thereto, may perform, in addition to the functions specified in subsection (a) of this regulation, the following procedures relating to the expanded administration of intravenous fluid therapy under the supervision of a registered professional nurse:

(1) Calculating;

(2) adding parenteral solutions to existing patent central and peripheral intravenous access devices or administration sets;

(3) changing administration sets;

(4) inserting intravenous access devices that meet these conditions:

(A) Do not exceed three inches in length; and

(B) are located in peripheral sites only;

(5) adding designated premixed medications to existing patent central and peripheral intravenous access devices or administration sets either by continuous or intermittent methods;

(6) maintaining the patency of central and peripheral intravenous access devices and administration sets with heparin or normal saline;

(7) changing dressings for central venous access devices;

(8) administering continuous intravenous drip analgesics and antibiotics; and

(9) performing the following procedures in any facility having continuous on-site registered professional nurse supervision:

(A) Admixing intravenous medications; and

(B) administering by direct intravenous push analgesics, antibiotics, antiemetics, diuretics, and corticosteroids.

(c) A licensed practical nurse shall not perform any of the following:

(1) Administer any of the following by intravenous route:

(A) Blood and blood products, including albumin;

(B) investigational medications;

(C) anesthetics, antianxiety agents, biological therapy, serums, hemostatics, immunosuppressants, muscle relaxants, human plasma fractions, oxytocics, sedatives, tocolytics, thrombolytics, anticonvulsants, cardiovascular preparations, antineoplastics agents, hematopoietics, autonomic drugs, and respiratory stimulants;

(D) intravenous fluid therapy in the home health setting, with the exception of the approved scope of practice authorized in subsection (a); or

(E) intravenous fluid therapy to any patient under the age of 12 or any patient weighing less than 80 pounds, with the exception of the approved scope of practice authorized in subsection (a);

(2) initiate total parenteral nutrition or lipids;

(3) titrate medications;

(4) draw blood from a central intravenous access device;

(5) remove a central intravenous access device or any intravenous access device exceeding three inches in length; or

(6) access implantable ports for any purpose.

(d) Licensed practical nurses qualified by the board before June 1, 2000 may perform those activities listed in subsection (a) and paragraph (b)(9)(A) regardless of their intravenous therapy course content on admixing.

(e) This regulation shall limit the scope of practice for each licensed practical nurse only with respect to intravenous fluid therapy and shall not restrict a licensed practical nurse's authority to care for patients receiving this therapy.

Authorized by and implementing K.S.A. 2001 Supp. 65-1136; effective Nov. 21, 1994; amended Dec. 13, 1996; amended June 12, 1998; amended Oct. 29, 1999; amended Jan. 24, 2003.

**AGENCY 65 STATE BOARD OF EXAMINERS IN OPTOMETRY
ARTICLE 8. MINIMUM STANDARDS FOR OPHTHALMIC SERVICES**

65-8-3. Records.

(a) The records of all patients shall contain at least the following information:

(1) the patients's full name, address, phone number and date of birth;

(2) a case history including all complaints;

(3) all objective and subjective findings taken;

(4) a diagnosis;

(5) the treatment plan given, including any ophthalmic or medical prescriptions;

(6) the final disposition, including any follow-up requirements or any patient referral;

(7) the date and location of the examination; and

(8) the name and signature of the licensee performing the examination.

(b) Any and all patient records required by these rules and regulations shall be maintained for at least five years.

(c) All findings and recordings entered into the patient records shall be made using normally accepted nomenclature and units of measure.

Authorized by K.S.A. 74-1504(a)(6); implementing K.S.A. 1991 Supp. 65-1502; effective May 18, 1992.

AGENCY 68 KANSAS STATE BOARD OF PHARMACY
ARTICLE 7. MISCELLANEOUS PROVISIONS

68-7-11. Medical care facility pharmacy. The scope of pharmaceutical services within a medical care facility pharmacy shall conform to the following requirements:

(a) The pharmacist-in-charge shall be responsible for developing programs and supervising all personnel in the distribution and control of drugs and all pharmaceutical services in the medical care facility.

(b) The pharmacist-in-charge shall develop a policy and procedure manual governing the storage, control, and distribution of drugs within the medical care facility. The pharmacist-in-charge shall submit the policy and procedure manual for approval to the pharmacy and therapeutics committee or an equivalent committee governing the security, control, and distribution of drugs within the facility.

(c) The pharmacist-in-charge shall be responsible for the maintenance of all emergency medication kits.

(d) The pharmacist-in-charge shall be responsible for developing procedures for the distribution and control of drugs within the medical care facility when a pharmacist is not on the premises. These procedures shall be consistent with the following requirements:

(1) Inpatient service. Drugs may be obtained upon a prescriber's medication order for administration to the inpatient by a designated registered professional nurse or nurses with approval and supervision of the pharmacist-in-charge. Adequate records of these withdrawals shall be maintained.

(2) Emergency outpatient service.

(A) An interim supply of prepackaged drugs shall be supplied to an outpatient only by a designated registered professional nurse or nurses pursuant to a prescriber's medication order when a pharmacist is not on the premises and a prescription cannot be filled. The interim supply shall be labeled with the following information:

(i) The name, address, and telephone number of the medical care facility;

(ii) the name of the prescriber. The label shall include the name of the practitioner and, if involved, the name of either the physician's assistant (PA) or the advanced registered nurse practitioner (ARNP);

(iii) the full name of the patient;

(iv) the identification number assigned to the interim supply of the drug or device by the medical care facility pharmacy;

(v) the date the interim supply was supplied;

(vi) adequate directions for use of the drug or device;

(vii) the beyond-use date of the drug or device issued;

(viii) the brand name or corresponding generic name of the drug or device;

(ix) the name of the manufacturer or distributor of the drug or device, or an easily identified abbreviation of the manufacturer's or distributor's name;

(x) the strength of the drug;

(xi) the contents in terms of weight, measure, or numerical count; and

(xii) necessary auxiliary labels and storage instruction, if needed.

(B) The interim supply shall be limited in quantity to an amount sufficient to supply the outpatient's needs until a prescription can be filled. Adequate records of the distribution of the interim supply shall be maintained and shall include the following information:

(i) The original or a copy of the prescriber's order, or if an oral order, a written record prepared by a designated registered professional nurse or nurses that reduces the oral order to writing. The written record shall be signed by the designated registered professional nurse or nurses and the prescriber; and

(ii) the name of the patient; the date supplied; the drug or device, strength, and quantity distributed; directions for use; the prescriber's name; and, if appropriate, the DEA number.

(3) The designated registered professional nurse or nurses may enter the medical care facility pharmacy and remove properly labeled pharmacy stock containers, commercially labeled packages, or properly labeled prepackaged units of drugs. The registered professional nurse shall not transfer a drug from one container to another for future use, but may transfer a single dose from a stock container for immediate administration to the ultimate user.

(e) The pharmacist-in-charge of the medical care facility pharmacy shall maintain documentation of at least quarterly checks of drug records and conditions of drug storage, in all locations within the facility, including nursing stations, emergency rooms, outpatient departments, and operating suites.

(f) The pharmacist-in-charge shall participate with the pharmacy and therapeutics committee or an equivalent committee in formulating broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, and safety procedures for drugs within the medical care facility.

(g) The pharmacist-in-charge shall be responsible for establishing a drug recall procedure that can be effectively implemented.

(h) (1) The pharmacist-in-charge shall be responsible for developing written procedures for maintaining records of drug distribution, prepackaging, and bulk compounding. Prepackaged drugs shall include the following information:

(A) The brand name or corresponding generic name of the drug;

(B) the name of the manufacturer or distributor of the drug, or an easily identified abbreviation of the manufacturer's or distributor's name;

(C) the strength of the drug;

(D) the contents in terms of weight, measure, or numerical count;

(E) the lot number; and

(F) the beyond-use date.

(2) Prepackaged drugs shall be packaged in suitable containers and shall be subject to all other provisions of the Kansas state board of pharmacy rules and regulations under the uniform controlled substances act of the state of Kansas and under the pharmacy act of the state of Kansas.

Before releasing any drugs or devices from the pharmacy, the pharmacist shall verify the accuracy of all prepackaging and the compounding of topical and oral drugs.

(i) The pharmacist-in-charge shall assure that the medical care facility maintains adequate drug information references commensurate with services offered and a current copy of the Kansas pharmacy act, the Kansas uniform controlled substances act, and current rules and regulations under both acts.

(j) The pharmacist-in-charge shall be responsible for pharmacist supervision of all pharmacy technicians and for confining their activities to those functions permitted by the pharmacy practice act. Records shall be maintained describing the following:

(1) The training and related education for non-discretionary tasks performed by pharmacy technicians; and

(2) written procedures designating the person or persons functioning as pharmacy technicians, describing the functions of the pharmacy technicians, and documenting the procedural steps taken by the pharmacist-in-charge to limit the functions of pharmacy technicians to nondiscretionary tasks.

(k) The pharmacist-in-charge shall be responsible for establishing policies and procedures for the mixing or preparation of parenteral admixtures. Whenever drugs are added to intravenous solutions, distinctive supplemental labels shall be affixed that indicate the name and amount of the drug added, the date and the time of addition, the beyond-use date, storage instructions, and the name or initials of the person who prepared the admixture. The pharmacist-in-charge shall comply with all requirements of K.A.R. 68-13-1. Before the parenteral admixture is released from the pharmacy, the pharmacist shall verify the accuracy of all parenteral admixtures prepared by pharmacy technicians.

(l) The pharmacist shall interpret the prescriber's original order, or a direct copy of it, before the drug is distributed and shall verify that the medication order is filled in strict conformity with the direction of the prescriber. This requirement shall not preclude orders transmitted by the prescriber through electronic transmission. Variations in this procedure with "after-the-fact" review of the prescriber's original order shall be consistent with medical care facility procedures established by the pharmacist-in-charge. Each medication order shall be reviewed by a pharmacist within seven days of the date it was written.

(m) Pharmacy services to outpatients during pharmacy hours shall be in accordance with the board's rules and regulations, K.S.A. 65-1625 et seq., and K.S.A. 65-4101 et seq., and amendments thereto, governing community pharmacy practice.

(n) The pharmacist-in-charge shall be responsible for the security of the pharmacy, including the drug distribution systems and personnel.

(1) When a pharmacist is on the premises but not in the pharmacy, a pharmacy technician may be in the pharmacy. A pharmacy technician shall not distribute any drug or device out of the pharmacy when a pharmacist is not physically in the pharmacy unless authorized by the pharmacist.

(2) When a pharmacist is not on the premises, no one shall be permitted in the pharmacy except the designated registered professional nurse or nurses.

Authorized by K.S.A. 65-1630; implementing K.S.A. 65-1648, K.S.A. 1999 Supp. 65-1642 and 65-1626; effective, E-77-39, July 22, 1976; effective Feb. 15, 1977; amended May 1, 1978; amended May 1, 1988; amended May 1, 1989; amended Dec. 27, 1999; amended April 28, 2000.

AGENCY 71 KANSAS DENTAL BOARD
ARTICLE 1. GENERAL RULES

71-1-15. Dental recordkeeping requirements. For the purposes of K.S.A. 65-1436 and amendments thereto, each licensee shall maintain for each patient an adequate dental record for 10 years after the date any professional service was provided. Each record shall disclose the justification for the course of treatment and shall meet all of the following minimum requirements:

- (a) It is legible.
- (b) It contains only those terms and abbreviations that are comprehensible to similar licensees.
- (c) It contains adequate identification of the patient.
- (d) It indicates the date any professional service was provided.
- (e) It contains pertinent and significant information concerning the patient's condition.
- (f) It reflects what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each.
- (g) It indicates the initial diagnosis and the patient's initial reason for seeking the licensee's services.
- (h) It indicates the medications prescribed, dispensed, or administered and the quantity and strength of each.
- (i) It reflects the treatment performed or recommended.
- (j) It documents the patient's progress during the course of treatment provided by the licensee.

Authorized by K.S.A. 74-1406; implementing K.S.A. 65-1436; effective May 1, 1988; amended Feb. 20, 2004.

AGENCY 92 KANSAS DEPARTMENT OF REVENUE
ARTICLE 19. KANSAS RETAILERS' SALES TAX

92-19-1b. Collection schedules for state and local sales tax.

- (a) Except as provided in K.S.A. 12-189a, and amendments thereto, Kansas retailers shall charge and collect sales tax on each taxable retail sale at a combined tax rate equal to the sum of the state tax rate established by K.S.A. 79-3603, and amendments thereto, plus any applicable local tax rate established under K.S.A. 12-187, and amendments thereto.
- (b) Tax collection schedules for each of the combined sales tax rates shall be published by the department and given to retailers upon request.
- (c) The state and local sales tax to be charged to a consumer shall be computed by multiplying the selling price by the applicable combined tax rate in effect. Each retailer using machine or computer billings shall use a straight percentage basis for calculating the tax on its billings. If the calculation of the sales tax to be charged results in a fraction of a cent, the tax liability shall be rounded up or down to the nearest whole cent. If the fraction is an even one-half cent, the liability shall be rounded to the next highest whole cent. No tax shall be charged to a consumer when the calculation of the tax to be charged totals less than one-half cent.
- (d) The sales tax payable to the department by a retailer shall be the product of the applicable combined state and local tax rate multiplied by the retailer's taxable gross receipts, regardless of the amount that is collected from consumers by use of the authorized method for computing taxes.

Authorized by K.S.A. 1997 Supp. 12-189, K.S.A. 79-3618 and 79-3619; implementing K.S.A. 1997 Supp. 12-187 and 12-189, K.S.A. 12-189a, 79-3603, and 79-3619; effective June 26, 1998.

92-19-3. Credit, conditional, and installment sales.

(a) When a retailer makes credit, conditional, or installment sales, the retailer may pay tax on the total amount of collections made during each reporting period or, if the retailer's books are regularly kept on an accrual basis, on the total amount of sales accrued for each reporting period. When the retailer adopts one basis of reporting for sales tax purposes, the retailer shall not change from that basis without first obtaining the permission of the director of taxation.

(b) If the retailer adopts the accrual basis for reporting taxable sales, the retailer shall account for all periodic adjustments to reported bad debts, including the final adjustment when debts are charged off the retailer's books for federal income tax purposes. If any portion of the bad debts is recovered after the final adjustment, the retailer shall include the recovery and tax in the next sales tax return.

(c) When tangible personal property or taxable services are sold on deferred payments and the deferred payments are covered by a negotiable note or notes or an assignable conditional sales contract, the retailer shall remit the tax on the total selling price of the property or service at the time the sale is made and report it in the retailer's next sales tax return.

(d) Interest, finance, or carrying charges on installment sales shall not be taxable when these charges are separately made and shown by the retailer on bills rendered to the consumer.

Authorized by K.S.A. 79-3618; implementing K.S.A. 79-3602, 79-3607, 79-3609; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972; amended May 1, 1988; amended June 26, 1998.

92-19-7. Leased departments. Where a person engaged in the business of selling tangible personal property or taxable services has leased certain parts of the premises wherein that business is conducted by other persons for use in selling tangible personal property or services, each such lessee shall make a separate return to the state: *Provided*, That the lessee keeps separate books of account and makes his own collections on account of the sales. If the lessor keeps the books for the lessee, the lessor must render a consolidated return, including therein the gross receipts from the operations of the business conducted by the lessee.

Authorized by K.S.A. 79-3608, 79-3618, K.S.A. 1971 Supp. 79-3602, 79-3603; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972.

92-19-10. Repossessed property. When the original retailer repossesses tangible personal property and resells it to a final user or consumer, the gross receipts from the sale are taxable. When tangible personal property is repossessed and resold by a bank, savings and loan institution, credit union or finance company licensed pursuant to the Kansas uniform consumer credit code, the sale qualifies as an isolated or occasional sale pursuant to K.S.A. 1986 Supp. 79-3602(j) and amendments.

When a retailer sells tangible personal property on credit and later repossesses the tangible personal property sold, the retailer shall use one of the following methods for recording the transaction:

(1) If the retailer's records are kept on the accrual basis so that the total selling price of the repossessed property was previously reported, the retailer may report the unpaid balance as a deduction from the gross receipts on the retailer's next tax return.

(2) If the retailer included in the gross receipts only the amount of cash actually received from the sale of the repossessed property, the retailer shall not receive credit for the return of the repossessed property to the retailer's stock.

Authorized by K.S.A. 79-3618, implementing K.S.A. 1986 Supp. 79-3602, 79-3603 as amended by L. 1987, Ch. 182, Sec. 108, K.S.A. 1986 Supp. 79-3607; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972; amended May 1, 1988.

92-19-11. Property purchased for resale, but used by purchaser. If a wholesaler or retailer takes tangible personal property from a stock of goods to use for personal consumption or for gifts, he shall enter on his books the amount of the cost of all tangible personal property so removed from stock for his personal consumption or as gifts, and, as the ultimate consumer, shall pay the tax thereon.

Authorized by K.S.A. 79-3618, K.S.A. 1971 Supp. 79-3602, 79-3603; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972.

92-19-12. Newspapers, magazines, periodicals, trade journals, publications and other printed matter.

(a) Newspapers, magazines, periodicals, trade journals, publications and other printed matter are tangible personal property and the receipts from retail sale of these items are taxable.

(b) When subscriptions for newspapers, magazines, periodicals, trade journals, publications and other printed matter are taken within the state of Kansas, sent to a printer or publishing house outside Kansas and the publication is thereafter mailed to the subscriber within Kansas, the receipts from the subscriptions are taxable.

(c) When newspapers, trade publications, advertising pamphlets, circulars and other publications, are distributed free of charge, the person printing or publishing the publication for sale to the distributor is deemed to be the seller thereof and must collect the tax.

(d) Each person who prints or produces and distributes publications, free of charge, is regarded as the final user or consumer of all materials used to print or produce the publication. For tax purposes, the printer or publisher shall pay sales tax on all purchases of materials used to print or produce the publication.

If a person prints or publishes tangible personal property for sale to consumers, and also prints or publishes publications which are distributed free of charge, a person may purchase all materials used in the printing and publishing process exempt from sales tax. When a person prints or publishes the publication for distribution free of charge, that person shall include the cost of all exempt materials purchased for use in printing or producing that publication on the sales tax return and impose sales tax on that amount.

Authorized by K.S.A. 79-3618, K.S.A. 1986 Supp. 79-3602, 79-3603 as amended by L. 1987, Ch. 182, Sec. 108, 79-3606, as amended by L. 1987, Ch. 64, Sec. 1; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972; amended May 1, 1988.

92-19-20. Gas, water, certain fuel and electricity.

(a) An exemption for gas, fuel or electricity shall not be allowed when utilized for the purpose of heating, cooling, and lighting buildings or business premises except electricity, gas, fuel and water actually used by hotels and motels in rented rooms taxable under K.S.A. 79-3603.

(b) An exemption for gas, water, fuel, and electricity shall not be allowed when utilized for the purpose of maintaining buildings, business premises, offices, plants, or warehouses except gas, fuel and electricity used for the operation of equipment in the actual process of providing services taxable under K.S.A. 79-3603(e) and (m). The following list is not exclusive but is an indication of the types of equipment and devices exempted when power is used in their operation:

- (1) Automatic pinsetters, ball returns, telescore screens and scorer's tables in bowling alleys;

- (2) ferris wheels, merry-go-rounds and other carnival rides;
- (3) baseball pitching machines if rental fees are charged;
- (4) pinball machines;
- (5) movie projecting equipment and movie screens in theaters, and other similar devices.

(c) When claiming an exemption, the following procedures and conditions shall apply:

- (1) When gas, electricity, or water is furnished through one meter for both taxable and exempt purposes, the taxpayer shall have the burden of establishing the exempt portion or percentage of the gas, water or electricity.
- (2) The purchaser shall furnish the supplier a statement to enable the supplier to determine the percentage of the gas, water and electricity subject to exemption under K.S.A. 79-3606(f) and (n). The formula and computations used in determining the exemption shall be available for inspection any time by the department of revenue.
- (3) The purchaser shall file a revised exemption statement with the supplier when the percentage used in processing tangible personal property changes.

(d) Tax is due on each payment for taxable gas, water, and electricity whether in the form of a minimum charge, a flat rate, or otherwise, and regardless if there is actual consumption.

(e) When an owner or operator of an office building or apartment house purchases gas, water, or electricity through a single meter, and remeters the gas, water, and electricity to their tenants through private meters, the owner or operator is deemed the final user or consumer of the gas, water, and electricity and shall pay the tax on all bills rendered on these utilities.

Authorized by K.S.A. 79-3618; implementing K.S.A. 1985 Supp. 79-3602, 79-3603 as amended by L. 1985, Ch. 386, Sec. 1, 79-3606 as amended by L. 1985, Ch. 384, Sec. 1, 79-3608; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; amended, E-71-21, July 1, 1971; amended Jan. 1, 1972; amended May 1, 1987.

92-19-21. Meals or drinks.

(a) Each boardinghouse shall pay the tax on their purchases of food and other supplies. When a boardinghouse serves meals only to persons regularly boarding there and not to the public, sales of these meals are not taxable. However, if a boardinghouse holds itself out as ready and willing to serve meals to the public, the sale of each meal shall be taxable.

(b) When meals are furnished by employers to employees and a charge is made, the employer must remit the tax on the price of the sales. When meals are furnished by employers to employees at no charge, the furnishing of meals does not constitute a sale and is not taxable.

(c) When a private or public elementary or secondary school, or a public or private nonprofit educational institution operates its lunch room, cafeteria, or dining room for the purpose of providing meals for its respective students or teachers, the school or institution shall not be considered to be engaged in the business of regularly selling meals or drinks to the public and shall not collect or remit tax on these sales.

When a public or private elementary or secondary school or a public or private nonprofit educational institution makes its cafeteria, lunch room, or dining room available for use by the general public, the school or institution shall be considered to be in the business of conducting a place in which meals or drinks are regularly sold to the public, and shall collect and remit the sales tax. A caterer or concessionaire operating a cafeteria, lunch or dining room on

the premises of any public or private elementary or secondary school or public or private nonprofit educational institution shall collect and remit sales tax.

(d) When a public or private nonprofit hospital operates a lunch room, cafeteria, or dining room for the exclusive purpose of providing meals for its respective employees and staff the hospital shall not be considered to be engaged in conducting a place where meals or drinks are regularly sold to the public and shall not collect and remit tax on these sales.

When a public or private nonprofit hospital makes its cafeteria, lunch room, or dining room available for use by the general public, the hospital shall be considered to be in the business of conducting a place where meals or drinks are regularly sold to the public and shall collect and remit the sales tax. Caterers or concessionaires operating cafeterias, lunch, or dining rooms on the premises of any public or private nonprofit hospital shall collect and remit sales tax.

(e) The sale of a meal or other tangible personal property, consumed or not, while on a railway train or a dining car operated in or through Kansas, is deemed a sale at retail. Gross receipts from the sale of meals or other tangible personal property are taxable if the meals or tangible personal property are ordered within the boundaries of Kansas.

Authorized by K.S.A. 79-3618; implementing K.S.A. 1985 Supp. 79-3602, 79-3603 as amended by L. 1986, Ch. 386, Sec. 1; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972; amended May 1, 1975; amended May 1, 1987.

92-19-25b. Exemption certificates.

(a) All retail sales shall be presumed to be taxable. The burden of proving that a sale is exempt from tax shall be on the vendor, unless the vendor takes an exemption certificate from the purchaser in good faith.

(b) A vendor shall be deemed to have accepted an exemption certificate in good faith when the vendor maintains the completed certificate as part of its records, has ascertained the identity of the person or entity who presents the certificate, and has not been shown by the department by a preponderance of evidence to have had knowledge that the presentation of the certificate was improper.

(c) Exemption certificates shall substantially comply with the following format:

KANSAS EXEMPTION CERTIFICATE

I certify that the sale of tangible personal property or service by:

___ (Vendor's name)

___ of ___, Kansas, to me or to the entity that I represent is exempt from the tax levied by the Kansas retailers' sales and compensating tax act for the following reasons:

___ As purchaser, I understand and agree that if the property or service is used in any manner that is not exempt from tax under the act, the entity that I represent becomes liable for the tax, as do I personally.

Date: ___

Purchaser: ___

(Signature and SSN or FEIN)

Name of the entity: ___

Address: ___

(d) Each exemption certificate issued by a nonprofit entity claiming an exemption shall contain the name and address of the entity; identify the subsection of K.S.A. 79-3606, and amendments thereto, under which the exemption is claimed; be signed by an officer, office manager, or other administrator of the entity; and contain the drivers license number of the signer. As a condition of honoring these exemption claims, a vendor may require that payment be made on the entity's check, warrant, or voucher, or be charged to the entity's account.

(e) A resale exemption certificate may be issued by a registered retailer to claim exemption from tax for purchases of property or services that the retailer intends to resell on the normal course of business or that the retailer is unable to determine will be resold or used by the retailer for some other purpose. Resale exemption certificates shall substantially comply with the following format:

KANSAS RESALE EXEMPTION CERTIFICATE

___ (Name of purchaser)

___ (Address of purchaser)

___ I hereby certify that: I hold valid retailer registration No. ___ issued pursuant to the Kansas sales and compensating tax law;

I am engaged in the business of selling:

___; The tangible personal property described herein which I shall purchase from:

___ (Vendor's name)

___ will be resold by me in the form of tangible personal property;

I further agree that, if any of the property is used for any purpose other than retention, demonstration, or display while holding it for resale in the regular course of business, I will report and pay Kansas state and local sales tax to the Kansas Department of Revenue, based on the amount that I paid for the property.

Description of property to be purchased: ___

Date: ___

___ (Signature of purchaser or authorized agent and SSN or FEIN)

(f) Each purchaser claiming a resale exemption shall complete the certificate either by listing the particular property claimed to be for resale or by describing the types of property that are resold in the normal course of the purchaser's business. When a purchaser buys property for resale that is not of the type normally resold in the purchaser's line of business, the vendor may require the purchaser to issue a separate resale exemption certificate that lists the property and states that it is being purchased for resale. A vendor may require a purchaser to provide a copy of its registration certificate as a condition for honoring a resale exemption certificate.

(g) Vendors shall keep a record of each exempt sale of property or services made, showing the date, amount, consumer's name and address, item or service sold, and other pertinent information needed to support each deduction taken on a return. Each vendor shall make such records and exemption certificates available to the department for inspection. Each exemption certificate shall be retained by the vendor for at least three years after the end of the year in which the certificate was last honored or until the final determination of any audit or assessment that includes a period during which the certificate was honored.

Authorized by K.S.A. 79-3606, 79-3618; implementing K.S.A. 79-3602, 79-3603, 79-3609, 79-3610, 79-3611; effective June 26, 1998.

92-19-29. Sales in interstate commerce. When tangible personal property is sold within the state and the seller is obligated to deliver it to a point outside the state or to deliver it to a carrier or to the mails for transportation to a point without the state, the retail sales tax does not apply: *Provided*, The property is not returned to a point within this state. The most acceptable proof of transportation outside the state will be:

- (a) A waybill or bill of lading made out to the seller's order calling for delivery; or
- (b) An insurance or registry receipt issued by the United States postal department, or a post office department's receipt; or
- (c) A trip sheet signed by the seller's delivery agent and showing the signature and address of the person outside the state who received the delivered goods.

However, where tangible personal property pursuant to a sale is delivered in this state to the buyer or his agent other than a common carrier, the sales tax applies, notwithstanding that the buyer may subsequently transport the property out of this state.

Authorized by K.S.A. 79-3618, K.S.A. 1971 Supp. 79-3602, 79-3606; effective, E-70-33, July 1, 1970; effective, E-71-8, Jan. 1, 1971; effective Jan. 1, 1972.

92-19-33. Permanent extensions of time to file sales and use tax returns.

(a) A permanent extension of not more than 60 days, may be granted by the director of taxation, for good cause, for filing of sales or compensating use returns and for payment of the tax that is due. A request for an extension shall meet the following requirements:

- (1) Be submitted in writing;
- (2) explain why accurate returns cannot reasonably be filed by the normal due date; and
- (3) set forth any additional facts relied on to establish good cause for granting the extension.

(b) The taxpayer shall be notified in writing when the request is granted or denied. The grant of a permanent extension may be conditioned on the taxpayer's acceptance of and compliance with a payment plan for remitting any additional interest that may be due because of the extension.

Authorized by K.S.A. 2000 Supp. 79-3618, K.S.A. 79-3707; implementing K.S.A. 79-3607, K.S.A. 2000 Supp. 79-3706; effective May 1, 1979; amended May 1, 1984; amended July 27, 2001.

92-19-36. Jeopardy assessments. The following actions by any person liable for tax under the Kansas retailers' sales tax act shall be deemed reason to believe that a taxpayer is about to depart from the state, or to remove his property therefrom, or to conceal himself or his property therein, or to do any other act which tends to prejudice, jeopardize, or render wholly or partly ineffectual the collection of sales tax: (a) Failure to file sales tax returns after notice as provided by K.S.A. 79-3613, and subsequent termination of business operations by the retailer; or (b) failure to file sales tax returns after notice as provided by K.S.A. 79-3613, and continuation of the act of making retail sales.

Authorized by K.S.A. 79-3610, 79-3618; effective, E-80-2, Jan. 18, 1979; effective May 1, 1979.

**AGENCY 100 KANSAS STATE BOARD OF HEALING ARTS
ARTICLE 22. DISHONORABLE CONDUCT**

100-22-1. Release of records.

(a) Unless otherwise prohibited by law, each licensee shall, upon receipt of a signed release from a patient, furnish a copy of the patient record to the patient, to another licensee designated by the patient, or to a patient's legally designated representative. However, if the licensee reasonably determines that the information within the patient record is detrimental to the mental or physical health of the patient, then the licensee may withhold the record from the patient and furnish the record to another licensee designated by the patient.

(b) A licensee may charge a person or entity for reasonable costs to retrieve or reproduce a patient record. A licensee shall not condition the furnishing of a patient record to another licensee upon prepayment of these costs.

(c) Any departure from this regulation shall constitute prima facie evidence of dishonorable conduct pursuant to K.S.A. 65-2836(b), and any amendments thereto.

Authorized by K.S.A. 65-2865; implementing K.S.A. 1997 Supp. 65-2836, as amended by L. 1998, Ch. 142, Sec. 12; effective May 1, 1985; amended Nov. 13, 1998.

100-22-2. Description of professional activities.

(a) Any person applying for an exempt license shall divulge on the application for such license a description of all professional activities related to the healing arts such person intends to perform if issued an exempt license.

(b) Any person holding an exempt license shall, at the time of renewal, divulge on the renewal application all professional activities related to the healing arts such person intends to perform during the renewal period.

(c) Any departure from subsection (a) or (b) may constitute evidence of dishonorable conduct pursuant to K.S.A. 1986 Supp. 65-2836(b) as amended by L. 1987, Ch. 176, Sec. 5 as further amended by L. 1987, Ch. 242, Sec. 2 and any amendments thereto.

Authorized by K.S.A. 65-2865; implementing K.S.A. 1986 Supp. 65-2836 as amended by L. 1987, Ch. 176, Sec. 5 as further amended by L. 1987, Ch. 242, Sec. 2; effective, T-88-52, Dec. 16, 1987; effective May 1, 1988.

**AGENCY 100 KANSAS STATE BOARD OF HEALING ARTS
ARTICLE 24. PATIENT RECORDS**

100-24-1. Adequacy; minimal requirements.

(a) Each licensee of the board shall maintain an adequate record for each patient for whom the licensee performs a professional service.

(b) Each patient record shall meet these requirements:

- (1) Be legible;
- (2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;
- (3) contain adequate identification of the patient;
- (4) indicate the dates any professional service was provided;

- (5) contain pertinent and significant information concerning the patient's condition;
- (6) reflect what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each;
- (7) indicate the initial diagnosis and the patient's initial reason for seeking the licensee's services;
- (8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;
- (9) reflect the treatment performed or recommended;
- (10) document the patient's progress during the course of treatment provided by the licensee; and
- (11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the licensee.

(c) Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the licensee's own hand-writing.

(d) Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form. The final form shall accurately reflect the care and services rendered to the patient.

(e) For purposes of implementing the healing arts act and this regulation, an electronic patient record shall be deemed a written patient record if the electronic record cannot be altered and if each entry in the electronic record is authenticated by the licensee.

Authorized by K.S.A. 65-2865; implementing K.S.A. 1997 Supp. 65-2837, as amended by L. 1998, ch. 142, § 19 and L. 1998, ch. 170, § 2; effective, T-87-42, Dec. 19, 1986; effective May 1, 1987; amended June 20, 1994; amended Nov. 13, 1998.

100-24-2. Patient record storage.

(a) Each licensee shall maintain the patient record for a minimum of 10 years from the date the licensee provided the professional service recorded. Any licensee may designate an entity, another licensee, or health care facility to maintain the record if the licensee requires the designee to store the record in a manner that allows lawful access and that maintains confidentiality.

(b) Patient records may be stored by an electronic data system, microfilm, or similar photographic means. A licensee may destroy original paper records stored in this manner if the stored record can be reproduced without alteration from the original.

(c) Each electronically stored record shall identify existing original documents or information not included in that electronically stored record.

Authorized by K.S.A. 65-2865; implementing K.S.A. 1997 Supp. 65-2837, as amended by L. 1998, Ch. 170, Sec. 2; effective Nov. 13, 1998.

100-24-3. Notice of location of records upon termination of active practice. Each licensee of the board who terminates the active practice of the healing arts within this state shall, within 30 days after terminating the active practice, provide to the board the following information:

- (a-) The location where patient records are stored;

(b) if the licensee designates an agent to maintain the records, the name, telephone number, and mailing address of the agent;

(c) the date on which the patient records are scheduled to be destroyed, as allowed by K.A.R. 100-24-2.

Authorized by K.S.A. 65-2865; implementing K.S.A. 1997 Supp. 65-2837, as amended by L. 1998, ch. 142, § 19 and L. 1998, ch. 170, § 2 and K.S.A. 65-2865; effective May 7, 1999.