

907 KAR 15:010. Coverage provisions and requirements regarding behavioral health services provided by individual behavioral health providers, behavioral health provider groups, and behavioral health multi-specialty groups.

RELATES TO: KRS 205.520, Chapter 319, 369.101-369.120, 42 C.F.R. Part 2, 431.17, 45 C.F.R. Parts 160, 164, 20 U.S.C. 1400 et seq., 29 U.S.C. 701 et seq., 42 U.S.C. 290ee-3, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 12101 et seq., 1320d-2 - 1320d-8

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6311

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed individual behavioral health professionals who are independently enrolled in the Medicaid Program, practitioners working for or under the supervision of the individual behavioral health providers, and individual behavioral health professionals and practitioners under supervision working in behavioral health provider groups or in behavioral health multi-specialty groups.

Section 1. General Coverage Requirements. (1) For the department to reimburse for a service covered under this administrative regulation, the service shall:

- (a) Be medically necessary;
 - (b) Meet the coverage requirements established in Section 3 of this administrative regulation;
 - (c) Be provided to a recipient by:
 - 1. An individual behavioral health provider who:
 - a. Is enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;
 - b. Except as established in Section 2(1) of this administrative regulation, currently participates in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and
 - c. Is:
 - (i) A physician;
 - (ii) A psychiatrist;
 - (iii) An advanced practice registered nurse;
 - (iv) A physician assistant;
 - (v) A licensed psychologist;
 - (vi) A licensed psychological practitioner;
 - (vii) A certified psychologist with autonomous functioning;
 - (viii) A licensed clinical social worker;
 - (ix) A licensed professional clinical counselor;
 - (x) A licensed marriage and family therapist;
 - (xi) A licensed professional art therapist;
 - (xii) A licensed clinical alcohol and drug counselor; or
 - (xiii) A licensed behavior analyst;
 - 2. Any of the individual behavioral health professionals listed in subparagraph 1.c. of this paragraph who is working for:
 - a. A behavioral health provider group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;
- and

- (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; or
- b. A behavioral health multi-specialty group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
- 3. A behavioral health practitioner under supervision working for:
 - a. An individual behavioral health professional listed in subparagraph 1.c. of this paragraph who is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
 - b. A behavioral health provider group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; or
 - c. A behavioral health multi-specialty group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
- 4. A certified psychologist working under the supervision of a board-approved licensed psychologist who is:
 - a.(i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
 - b. Working for a behavioral health provider group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; or
 - c. Working for a behavioral health multi-specialty group that is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; or
- 5. An adult peer support specialist, family peer support specialist, youth peer support specialist, or registered alcohol and drug peer support specialist working for:
 - a. Any of the individual behavioral health professionals listed in subparagraph 1.c. of this paragraph who is:
 - (i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
 - (ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
 - b. A behavioral health provider group that is:

(i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; or

c. A behavioral health multi-specialty group that is:

(i) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(ii) Except as established in Section 2(1) of this administrative regulation, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

(d) Be billed to the department by the:

1. Individual provider who provided the service or under whose supervision the service was rendered in accordance with Section 3 of this administrative regulation;

2. Behavioral health provider group on behalf of which the service was rendered in accordance with Section 3 of this administrative regulation; or

3. Behavioral health multi-specialty group on behalf of which the service was rendered in accordance with Section 3 of this administrative regulation.

(2)(a) Face-to-face contact between a provider or practitioner and a recipient shall be required for each service except for:

1. Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collateral outpatient therapy is in the child's plan of care;

2. A family outpatient therapy service in which the corresponding current procedural terminology code establishes that the recipient is not present;

3. A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or others in which the corresponding current procedural terminology code establishes that the recipient is not present; or

4. A service planning activity in which the corresponding current procedural terminology code establishes that the recipient is not present.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(3) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(4) A service shall be:

(a) Stated in a recipient's plan of care; and

(b) Provided in accordance with a recipient's plan of care.

(5) A provider shall establish a plan of care for each recipient receiving services from the provider.

Section 2. Provider Participation. (1) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2) A provider shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the Act.

Section 3. Covered Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

(a) Mental health disorder;

- (b) Substance use disorder; or
- (c) Co-occurring mental health and substance use disorders.

(2) The following services shall be covered under this administrative regulation in accordance with the requirements established in this section:

(a) A screening provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A certified psychologist with autonomous functioning;
11. A licensed clinical and alcohol drug counselor;
12. A licensed professional art therapist; or
13. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

(b) An assessment provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A certified psychologist with autonomous functioning;
11. A licensed behavior analyst;
12. A licensed clinical alcohol and drug counselor;
13. A licensed professional art therapist; or
14. A behavioral health practitioner under supervision;

(c) Psychological testing provided by:

1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed psychological associate;
4. A certified psychologist with autonomous functioning; or
5. A certified psychologist;

(d) Service planning provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;

9. A licensed psychological practitioner;
 10. A certified psychologist with autonomous functioning;
 11. A licensed professional art therapist;
 12. A licensed behavior analyst; or
 13. A behavioral health practitioner under supervision except for a:
 - a. Certified alcohol and drug counselor; or
 - b. Licensed clinical alcohol and drug counselor associate;
- (e) Individual outpatient therapy, group outpatient therapy, collateral outpatient therapy, or crisis intervention services provided by:
1. A licensed psychologist;
 2. A licensed professional clinical counselor;
 3. A licensed clinical social worker;
 4. A licensed marriage and family therapist;
 5. A physician;
 6. A psychiatrist;
 7. An advanced practice registered nurse;
 8. A physician assistant;
 9. A licensed psychological practitioner;
 10. A certified psychologist with autonomous functioning;
 11. A licensed professional art therapist;
 12. A licensed behavior analyst;
 13. A licensed clinical alcohol and drug counselor; or
 14. A behavioral health practitioner under supervision;
- (f) Family outpatient therapy provided by:
1. A licensed psychologist;
 2. A licensed professional clinical counselor;
 3. A licensed clinical social worker;
 4. A licensed marriage and family therapist;
 5. A physician;
 6. A psychiatrist;
 7. An advanced practice registered nurse;
 8. A physician assistant;
 9. A licensed psychological practitioner;
 10. A certified psychologist with autonomous functioning;
 11. A licensed professional art therapist;
 12. A licensed clinical alcohol and drug counselor; or
 13. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;
- (g) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
1. A licensed psychologist;
 2. A licensed professional clinical counselor;
 3. A licensed clinical social worker;
 4. A licensed marriage and family therapist;
 5. A physician;
 6. A psychiatrist;
 7. An advanced practice registered nurse;
 8. A physician assistant;
 9. A licensed psychological practitioner;

10. A certified psychologist with autonomous functioning;
11. A licensed professional art therapist;
12. A licensed clinical alcohol and drug counselor; or
13. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

(h) Day treatment provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A certified psychologist with autonomous functioning;
11. A licensed professional art therapist;
12. A licensed behavior analyst;
13. A behavioral health practitioner under supervision;
14. An adult peer support specialist, family peer support specialist, or youth peer support specialist working under the supervision of an approved behavioral health services provider;
15. A registered alcohol and drug peer support specialist working under the supervision of an approved behavioral health services provider; or
16. A licensed clinical alcohol and drug counselor;

(i) Comprehensive community support services provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A certified psychologist with autonomous functioning;
11. A licensed professional art therapist;
12. A licensed behavior analyst; or
13. A behavioral health practitioner under supervision except for a:
 - a. Certified alcohol and drug counselor; or
 - b. Licensed clinical alcohol and drug counselor associate;

(j) Peer support, except as established in subsection (3)(a) of this section, provided by:

1. An adult peer support specialist working under the supervision of an approved behavioral health service provider;
2. A youth peer support specialist working under the supervision of an approved behavioral health service provider;
3. A family peer support specialist working under the supervision of an approved behavioral health services provider; or
4. A registered alcohol and drug peer support specialist working under the supervision of an approved behavioral health services provider;

(k) Intensive outpatient program services, except as established in subsection (3)(b) of this section, provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A behavioral health practitioner under supervision, except for a licensed assistant behavioral analyst;
11. A licensed professional art therapist; or
12. A licensed clinical alcohol and drug counselor; or

(l) Therapeutic rehabilitation program services provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A physician assistant;
9. A licensed psychological practitioner;
10. A certified psychologist with autonomous functioning;
11. A licensed professional art therapist;
12. A behavioral health practitioner under supervision except for a:
 - a. Certified alcohol and drug counselor;
 - b. Licensed clinical alcohol and drug counselor associate; or
 - c. Licensed assistant behavior analyst; or
13. An adult peer support specialist, family peer support specialist, or youth peer support specialist working under the supervision of an approved behavioral health services provider.

(3)(a) Peer support shall only be covered if provided by a behavioral health:

1. Provider group; or
2. Multi-specialty group.

(b) Intensive outpatient program services shall only be covered if provided by a behavioral health:

1. Provider group; or
2. Multi-specialty group.

(4)(a) A screening shall:

1. Determine the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorders;
2. Not establish the presence or specific type of disorder; and
3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:
 - a. Establish the presence or absence of a mental health disorder, substance use disorder,

or co-occurring disorders;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinical disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include psychological or psychiatric evaluations or assessments.

(c) Psychological testing shall:

1. Include:

a. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

b. Interpretation and a written report of testing results; and

2. Be performed by an individual who has met the requirements of KRS Chapter 319 related to the necessary credentials to perform psychological testing.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;

3. Shall be provided:

a. On-site at the provider's office;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include:

a. Further service prevention planning including:

(i) Lethal means reduction for suicide risk; or

(ii) Substance use disorder relapse prevention; or

b. Verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to noncrisis services if applicable.

(e)1. Service planning shall:

a. Involve assisting a recipient in creating an individualized plan for services needed for maximum reduction of a mental health disorder;

b. Involve restoring a recipient's functional level to the recipient's best possible functional level; and

c. Be performed using a person-centered planning process.

2. A service plan:

a. Shall be directed by the recipient;

b. Shall include practitioners of the recipient's choosing; and

c. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and well-being of the recipient; and

b. Recipient's recovery from a substance use disorder, mental health disorder, or co-

occurring mental health and substance use disorders;

2. Consist of:

- a. A face-to-face, one-on-one encounter between the provider and recipient; and
- b. A behavioral health therapeutic intervention provided in accordance with the recipient's

identified plan of care;

3. Be aimed at:

- a. Reducing adverse symptoms;
- b. Reducing or eliminating the presenting problem of the recipient; and
- c. Improving functioning; and

4. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

3. Family outpatient therapy shall:

a. Be provided to promote the:

- (i) Health and wellbeing of the recipient; and
- (ii) Recipient's recovery from a substance use disorder, mental health disorder, or co-occurring related disorders; and

b. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per individual unless additional time is medically necessary.

(h)1. Group outpatient therapy shall:

a. Be a behavioral health therapeutic intervention provided in accordance with a recipient's identified plan of care;

b. Be provided to promote the:

- (i) Health and well-being of the recipient; and
- (ii) Recipient's recovery from a substance use disorder, mental health disorder, or co-occurring mental health and substance use disorders;

c. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified plan of care;

d. Be provided to a recipient in a group setting:

- (i) Of nonrelated individuals except for multi-family group therapy; and
- (ii) Not to exceed twelve (12) individuals in size;

e. Focus on the psychological needs of the recipients as evidenced in each recipient's plan of care;

f. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

g. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

h. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary.

2. The group shall have a:

- a. Deliberate focus; and

- b. Defined course of treatment.
- 3. The subject of group outpatient therapy shall be related to each recipient participating in the group.
- 4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.
 - (i) 1. Collateral outpatient therapy shall:
 - a. Consist of a face-to-face behavioral health consultation:
 - (i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and
 - (ii) That is provided in accordance with the recipient's plan of care; and
 - b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.
 - 2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.
 - (j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:
 - 1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and
 - 2. Consist of:
 - a. Using a standardized screening tool to assess an individual for risky substance use behavior;
 - b. Engaging a recipient who demonstrates risky substance use behavior in a short conversation and providing feedback and advice to the recipient; and
 - c. Referring a recipient to additional mental health disorder, substance use disorder, or co-occurring disorders services if the recipient is determined to need other additional services to address the recipient's substance use.
 - (k) 1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:
 - a. A mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders; and
 - b. A high risk of out-of-home placement due to a behavioral health issue.
 - 2. Day treatment shall:
 - a. Consist of an organized, behavioral health program of treatment and rehabilitative services;
 - b. Include:
 - (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
 - (ii) Behavior management and social skills training;
 - (iii) Independent living skills that correlate to the age and development stage of the recipient; or
 - (iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and
 - c. Be provided:
 - (i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
 - (ii) On school days and during scheduled breaks;
 - (iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;

- (iv) Under the supervision of an approved behavioral health services provider; and
- (v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. To provide day treatment services, a provider shall have:

- a. The capacity to employ staff authorized to provide day treatment services in accordance with this section and to coordinate the provision of services among team members; and
- b. Knowledge of substance use disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(l)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in the community;

b. Be intended to ensure successful community living through the utilization of skills training as identified in the recipient's plan of care; and

c. Consist of using a variety of psychiatric or behavioral rehabilitation techniques to:

- (i) Improve emotional regulation skills;
- (ii) Improve crisis coping skills;
- (iii) Develop and enhance interpersonal skills;
- (iv) Improve daily living skills; and
- (v) Improve self-monitoring of symptoms and side effects.

2. To provide comprehensive community support services, a provider shall:

a. Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(i) of this section and to coordinate the provision of services among team members; and

b. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

(m)1. Peer support services shall:

a. Be emotional support that is provided by:

(i) An individual who has been trained and certified in accordance with 908 KAR 2:220 and who is experiencing or has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

(ii) A parent who has been trained and certified in accordance with 908 KAR 2:230 of a child having or who has had a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders to a parent or family member of a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

(iii) A family member who has been trained and certified in accordance with 908 KAR 2:230 of a child having or who has had a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders to a parent or family member of a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change; or

(iv) A registered alcohol and drug peer support specialist who is experiencing or has experienced a substance use disorder to a recipient by sharing a similar substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

- d. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient;
 - e. Be coordinated within the context of a comprehensive, individualized plan of care developed through a person-centered planning process;
 - f. Be identified in each recipient's plan of care; and
 - g. Be designed to directly contribute to the recipient's individualized goals as specified in the recipient's plan of care.
2. To provide peer support services, a provider shall:
- a. Have demonstrated:
 - (i) The capacity to provide peer support services for the behavioral health population being served including the age range of the population being served; and
 - (ii) Experience in serving individuals with behavioral health disorders;
 - b. Employ:
 - (i) Adult peer support specialists, family peer support specialists, or youth peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240; or
 - (ii) Registered alcohol and drug peer support specialists; and
 - c. Use an approved behavioral health services provider to supervise adult peer support specialists, family peer support specialists, or youth peer support specialists.
- (n)1. Intensive outpatient program services shall:
- a. Be an alternative to or transition from inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;
 - b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;
 - c. Be provided at least three (3) hours per day at least three (3) days per week; and
 - d. Include:
 - (i) Individual outpatient therapy;
 - (ii) Group outpatient therapy;
 - (iii) Family outpatient therapy unless contraindicated;
 - (iv) Crisis intervention; or
 - (v) Psycho-education.
2. During psycho-education the recipient or recipient's family member shall be:
- a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and
 - b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.
3. An intensive outpatient program services treatment plan shall:
- a. Be individualized; and
 - b. Focus on stabilization and transition to a lesser level of care.
4. To provide intensive outpatient program services, a provider shall:
- a. Be employed by a behavioral health multi-specialty group or behavioral health provider group; and
 - b. Have:
 - (i) Access to a board-certified or board-eligible psychiatrist for consultation;
 - (ii) Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;
 - (iii) The capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles;
 - (iv) The capacity to employ staff authorized to provide intensive outpatient program services

in accordance with this section and to coordinate the provision of services among team members;

(v) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;

(vi) Demonstrated experience in serving individuals with behavioral health disorders;

(vii) The administrative capacity to ensure quality of services;

(viii) A financial management system that provides documentation of services and costs; and

(ix) The capacity to document and maintain individual case records.

5. Intensive outpatient program services shall be provided in a setting with a minimum recipient-to-staff ratio of ten (10) to one (1).

(o)1. Therapeutic rehabilitation program services shall be:

a. A rehabilitative service for an:

(i) Adult with a severe mental illness; or

(ii) Individual under the age of twenty-one (21) years who has a severe emotional disability; and

b. Designed to maximize the reduction of a mental health disorder and the restoration of the individual's functional level to the individual's best possible functional level.

2. A recipient in a therapeutic rehabilitation program shall establish the recipient's own rehabilitation goals within the plan of care.

3. A therapeutic rehabilitation program shall:

a. Be delivered using a variety of psychiatric rehabilitation techniques;

b. Focus on:

(i) Improving daily living skills;

(ii) Self-monitoring of symptoms and side effects;

(iii) Emotional regulation skills;

(iv) Crisis coping skills; and

(v) Interpersonal skills; and

c. Be delivered individually or in a group.

(5) The extent and type of a screening shall depend upon the problem of the individual seeking or being referred for services.

(6) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(7) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

Section 4. Additional Limits and Noncovered Services or Activities. (1) The following services or activities shall not be covered under this administrative regulation:

(a) A service provided to:

1. A resident of:

a. A nursing facility; or

b. An intermediate care facility for individuals with an intellectual disability;

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the provider;

(c) A consultation or educational service provided to a recipient or to others;

(d) Collateral therapy for an individual aged twenty-one (21) years or older;

(e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face";

(f) Travel time;

(g) A field trip;

(h) A recreational activity;

(i) A social activity; or

(j) A physical exercise activity group.

(2)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except regarding collateral outpatient therapy as specified in Section 3(4)(i) of this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

(3)(a) Except as established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the recipient's medical record within three (3) visits, the service shall not be covered.

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

1. Crisis intervention;

2. A screening; or

3. An assessment.

(4) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.

(5) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:

(a) Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or

(b) Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

Section 5. Duplication of Service Prohibited. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an individual behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a behavioral health services organization.

Section 6. Records Maintenance, Documentation, Protection, and Security. (1) An individual provider, a behavioral health provider group, or a behavioral health multi-specialty group shall maintain a current health record for each recipient.

(2)(a) A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(b) The individual who provided the service shall date and sign the health record within forty-eight (48) hours of the date that the individual provided the service.

(3) A health record shall:

- (a) Include:
 1. An identification and intake record including:
 - a. Name;
 - b. Social Security number;
 - c. Date of intake;
 - d. Home (legal) address;
 - e. Health insurance information;
 - f. If applicable, the referral source's name and address;
 - g. Primary care physician's name and address;
 - h. The reason the individual is seeking help including the presenting problem and diagnosis;
 - i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:
 - (i) Where the individual is receiving treatment for the physical health diagnosis; and
 - (ii) The physical health provider's name; and
 - j. The name of the informant and any other information deemed necessary by the provider to comply with the requirements of:
 - (i) This administrative regulation;
 - (ii) The provider's licensure board, if applicable;
 - (iii) State law; or
 - (iv) Federal law;
 2. Documentation of the:
 - a. Screening;
 - b. Assessment;
 - c. Disposition if a disposition was performed; and
 - d. Six (6) month review of a recipient's plan of care each time a six (6) month review occurs;
 3. A complete history including mental status and previous treatment;
 4. An identification sheet;
 5. A consent for treatment sheet that is accurately signed and dated; and
 6. The individual's stated purpose for seeking services; and
 - (b) Be:
 1. Maintained in an organized central file;
 2. Furnished upon request to the:
 - a. Cabinet for Health and Family Services; or
 - b. For an enrollee, managed care organization in which the recipient is enrolled or has been enrolled in the past;
 3. Made available for inspection and copying by:
 - a. Cabinet for Health and Family Services' personnel; or
 - b. Personnel of the managed care organization in which the recipient is enrolled if applicable;
 4. Readily accessible; and
 5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient if the recipient received services beyond a screening.
- (4) Documentation of a screening shall include:
 - (a) Information relative to the individual's stated request for services; and
 - (b) Other stated personal or health concerns if other concerns are stated.
- (5)(a) A behavioral health practitioner's notes regarding a recipient shall:
 1. Be made within forty-eight (48) hours of each service visit; and
 2. Describe the:
 - a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

- b. Behavioral health practitioner's intervention;
 - c. Changes in the plan of care if changes are made; and
 - d. Need for continued treatment if deemed necessary.
- (b)1. Any edit to notes shall:
- a. Clearly display the changes; and
 - b. Be initialed and dated by the person who edited the notes.
2. Notes shall not be erased or illegibly marked out.
- (c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional within thirty (30) days of each service visit.
2. If services are provided by a behavioral health practitioner under supervision, there shall be a monthly supervisory note recorded by the supervision professional reflecting consultations with the practitioner working under supervision concerning the:
- a. Case; and
 - b. Supervising professional's evaluation of the services being provided to the recipient.
- (6) Immediately following a screening of a recipient, the behavioral health practitioner who performed the screening shall perform a disposition related to:
- (a) A provisional diagnosis;
 - (b) A referral for further consultation and disposition, if applicable; or
- (c)1. If applicable, termination of services and referral to an outside source for further services; or
2. If applicable, termination of services without a referral to further services.
- (7)(a) A recipient's plan of care shall be reviewed at least once every six (6) months.
- (b) Any change to a recipient's plan of care shall be documented, signed, and dated by the rendering practitioner and by the recipient or recipient's representative.
- (8)(a) Notes regarding services to a recipient shall:
- 1. Be organized in chronological order;
 - 2. Be dated;
 - 3. Be titled to indicate the service rendered;
 - 4. State a starting and ending time for the service; and
 - 5. Be recorded and signed by the rendering behavioral health practitioner and include the practitioner's professional title (for example, licensed clinical social worker).
- (b) Initials, typed signatures, or stamped signatures shall not be accepted.
- (c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other non-reimbursable contacts shall:
- 1. Be recorded in the notes; and
 - 2. Not be reimbursable.
- (9) A termination summary shall:
- (a) Be required, upon termination of services, for each recipient who received at least three (3) service visits; and
 - (b) Contain a summary of the significant findings and events during the course of treatment including the:
 - 1. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's plan of care;
 - 2. Final diagnosis of clinical impression; and
 - 3. Individual's condition upon termination and disposition.
 - (c) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.
- (10) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval

period shall be acceptable.

(11)(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, within ten (10) business days of the transfer or referral, transfer the recipient's health record in a manner that complies with the records' use and disclosure requirements as established in or required by:

- 1.a. The Health Insurance Portability and Accountability Act;
- b. 42 U.S.C. 1320d-2 to 1320d-8; and
- c. 45 C.F.R. Parts 160 and 164; or
- 2.a. 42 U.S.C. 290ee-3; and
- b. 42 C.F.R. Part 2.

(b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for care or treatment, the transferring provider shall, within forty-eight (48) hours of the transfer or referral, transfer the recipient's records in a manner that complies with the records' use and disclosure requirements as established in or required by:

- 1.a. The Health Insurance Portability and Accountability Act;
- b. 42 U.S.C. 1320d-2 to 1320d-8; and
- c. 45 C.F.R. Parts 160 and 164; or
- 2.a. 42 U.S.C. 290ee-3; and
- b. 42 C.F.R. Part 2.

(12)(a) If an individual behavioral health provider's, a behavioral health provider group's, or a behavioral health multi-specialty group's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, or a licensure suspension, the health records of the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall:

1. Remain the property of the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group; and
2. Be subject to the retention requirements established in subsection (13) of this section.

(b)1. If an individual behavioral health provider dies, the health records maintained by the individual behavioral health provider shall remain the property of the individual behavioral health provider.

2. An individual behavioral health provider shall have a written plan addressing how to maintain health records following the provider's death in a manner that complies with the retention requirements established in subsection (13) of this section.

(13)(a) Except as established in paragraph (b) or (c) of this subsection, an individual behavioral health provider, a behavioral health provider group, or a behavioral health specialty group shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) After a recipient's death or discharge from services, an individual behavioral health provider, a behavioral health provider group, or a behavioral health multi-specialty group shall maintain the recipient's record for the longest of the following periods:

1. Five (5) years unless the recipient is a minor; or
2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required pe-

riod.

(14)(a) An individual behavioral health provider, a behavioral health provider group, or a behavioral health multi-specialty group shall comply with 45 C.F.R. Chapter 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;
2. Not be disclosed to an unauthorized individual; and
3. Be disclosed to an authorized representative of:
 - a. The department;
 - b. Federal government; or
 - c. For an enrollee, the managed care organization in which the enrollee is enrolled.

(c)1. Upon request, an individual behavioral health provider, a behavioral health provider group, or a behavioral health multi-specialty group shall provide to an authorized representative of the department, federal government, or managed care organization if applicable, information requested to substantiate:

- a. Staff notes detailing a service that was rendered;
- b. The professional who rendered a service; and
- c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department or the managed care organization, if applicable.

2. Failure to provide information referenced in subparagraph 1. of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 7. Medicaid Program Participation Compliance. (1) An individual behavioral health provider, a behavioral health provider group, or a behavioral health multi-specialty group shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(2)(a) If an individual behavioral health provider, a behavioral health provider group, or a behavioral health multi-specialty group receives any duplicate payment or overpayment from the department, regardless of reason, the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

(3)(a) When the department makes payment for a covered service and the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group accepts the payment:

1. The payment shall be considered payment in full;
2. A bill for the same service shall not be given to the recipient; and
3. Payment from the recipient for the same service shall not be accepted by the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group.

(b)1. An individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:

- a. Recipient requests the service; and

b. Individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group makes the recipient aware in advance of providing the service that the:

- (i) Recipient is liable for the payment; and
- (ii) Department is not covering the service.

2. If a recipient makes payment for a service in accordance with subparagraph 1. of this paragraph, the:

a. Individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall not bill the department for the service; and

b. Department shall not:

- (i) Be liable for any part of the payment associated with the service; and
- (ii) Make any payment to the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group regarding the service.

(4)(a) An individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall attest by the individual behavioral health provider's signature or signature of an individual on behalf of a behavioral health provider group or behavioral health multi-specialty group that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:

- 1. Department or its designee;
- 2. Cabinet for Health and Family Services, Office of Inspector General or its designee;
- 3. Kentucky Office of Attorney General or its designee;
- 4. Kentucky Office of the Auditor for Public Accounts or its designee; or
- 5. United States General Accounting Office or its designee.

(c) If an individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group receives a request from the department to provide a claim, related information, related documentation, or record for auditing purposes, the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall provide the requested information to the department within the timeframe requested by the department.

(d)1. All services provided shall be subject to review for recipient or provider abuse.

2. Willful abuse by an individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall result in the suspension or termination of the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group from Medicaid Program participation.

(5)(a) If an individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group renders a Medicaid-covered service to a recipient, regardless of if the service is billed through the individual behavioral health provider's, behavioral health provider group's, or behavioral health multi-specialty group's Medicaid provider number or any other entity or individual including a non-Medicaid provider, the recipient shall not be charged or billed for the service.

(b) The department shall terminate from Medicaid Program participation an individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group that:

- 1. Charges or bills a recipient for a Medicaid-covered service; or
- 2. Participates in an arrangement in which an entity or individual bills a recipient for a Medicaid-covered service rendered by the individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group.

Section 8. Third Party Liability. An individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) An individual behavioral health provider, behavioral health provider group, or behavioral health multi-specialty group that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the individual behavioral health provider's, behavioral health provider group's, or behavioral health multi-specialty group's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 10. Auditing Authority. The department shall have the authority to audit any:

- (1) Claim;
- (2) Medical record; or
- (3) Documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010. (40 Ky.R. 2066; 2566; 2779; eff. 7-7-2014; 43 Ky.R. 1085; 1606; 1959; eff. 6-2-2017.)