

907 KAR 1:044. Coverage provisions and requirements regarding community mental health center behavioral health services.

RELATES TO: KRS 194A.060, 205.520(3), 205.8451(9), 422.317, 434.840-434.860, 42 C.F.R. 415.208, 431.52, 431 Subpart F

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450, 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding community mental health center (CMHC) behavioral health services provided to Medicaid recipients.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Face-to-face" means occurring:

(a) In person; or

(b) If authorized by 907 KAR 3:170, via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(5) "Federal financial participation" is defined in 42 C.F.R. 400.203.

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

(7) "Mental health associate" means an individual who meets the mental health associate requirements established in the Community Mental Health Center Behavioral Health Services Manual.

(8) "Professional equivalent" means an individual who meets the professional equivalent requirements established in the Community Mental Health Center Behavioral Health Services Manual.

(9) "Provider" is defined by KRS 205.8451(7).

(10) "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.0011(12).

(11) "Recipient" is defined by KRS 205.8451(9).

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the individual:

(1) Possesses a Master of Science in nursing with a specialty in psychiatric or mental health nursing;

(2)(a) Is a graduate of a four (4) year nursing educational program with a Bachelor of Science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting; or

(4)(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) Possesses at least three (3) years of experience in a mental health setting.

Section 3. Community Mental Health Center Behavioral Health Services Manual. The conditions for participation, services covered, and limitations for the community mental health center behavioral health services component of the Medicaid Program shall be as specified in:

- (1) This administrative regulation; and
- (2) The Community Mental Health Center Behavioral Health Services Manual.

Section 4. Covered Services. (1) Behavioral health services covered pursuant to this administrative regulation and pursuant to the Community Mental Health Center Behavioral Health Services Manual shall be rehabilitative mental health and substance use disorder services including:

- (a) Individual outpatient therapy;
- (b) Group outpatient therapy;
- (c) Family outpatient therapy;
- (d) Collateral outpatient therapy;
- (e) Therapeutic rehabilitation services;
- (f) Psychological testing;
- (g) Screening;
- (h) An assessment;
- (i) Crisis intervention;
- (j) Service planning;
- (k) A screening, brief intervention, and referral to treatment;
- (l) Mobile crisis services;
- (m) Assertive community treatment;
- (n) Intensive outpatient program services;
- (o) Residential crisis stabilization services;
- (p) Partial hospitalization;
- (q) Residential services for substance use disorders;
- (r) Day treatment;
- (s) Comprehensive community support services;
- (t) Peer support services; or
- (u) Parent or family peer support services.

(2)(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be:

1. Provided by a community mental health center that is:
 - a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and
 - b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671;
 2. Provided in accordance with:
 - a. This administrative regulation; and
 - b. The Community Mental Health Center Behavioral Health Services Manual; and
 3. Medically necessary.
- (b) 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.

Section 5. Electronic Documents and Signatures. (1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

- (2) A CMHC choosing to utilize electronic signatures shall:

- (a) Develop and implement a written security policy which shall:
 1. Be complied with by each of the center's employees, officers, agents, and contractors; and
 2. Stipulate which individuals have access to which electronic signatures and password authorization;
- (b) Ensure that electronic signatures are created, transmitted, and stored securely;
- (c) Develop a consent form that shall:
 1. Be completed and executed by each individual utilizing an electronic signature;
 2. Attest to the signature's authenticity; and
 3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and
- (d) Provide the department, immediately upon request, with:
 1. A copy of the provider's electronic signature policy;
 2. The signed consent form; and
 3. The original filed signature.

Section 6. No Duplication of Service. (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, on the same day of service.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient by a community mental health center on the same day of service.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

- (2) 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. Referral source and address of referral source;
 - g. Primary care physician 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, if available, regarding:
 - (i) Where the individual is receiving treatment for the physical health diagnosis; and
 - (ii) The physical health provider; and
 - j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:
 - (i) This administrative regulation;
 - (ii) The provider's licensure board;
 - (iii) State law; or
 - (iv) Federal law;
 2. Documentation of the:
 - a. Screening if the community mental health center performed the screening;
 - b. Assessment; and

c. Disposition;

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;

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the:

a. Cabinet for Health and Family Services upon request; or

b. Managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

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; and

(c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) 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.

(4)(a) Except as established in paragraph (b) or (c) of this subsection, a provider shall maintain a health record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

(b) After a recipient's death or discharge from services, a provider shall maintain the recipient's health record for the longest of the following periods:

1. Six (6) years unless the recipient is a minor; or

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

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

(5) A provider shall comply with 45 C.F.R. Part 164.

(6) 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.

(7)(a) A provider'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. Therapist's intervention;

c. Changes in the plan of care if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c) If services are provided by a practitioner working under supervision, there shall be a

monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

1. Case; and
2. Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider 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.

(9) Any change to a recipient's plan of care shall be documented, signed, and dated by the:

- (a) Rendering practitioner; and
- (b) Recipient or recipient's representative.

(10)(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 provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not covered under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and
2. Not be reimbursable.

(11)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and
2. Contain a summary of the significant findings and events during the course of treatment including the:

- a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's plan of care;
- b. Final diagnosis of clinical impression; and
3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who was terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) 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.

(13)(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 CMHC shall, if the recipient gives the CMHC written consent to do so, within ten (10) business days of the transfer or referral, transfer the recipient's health records in a manner that complies with the health 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 CMHC shall, within forty-eight (48) hours of the transfer or referral, transfer the recipient's health records in a manner that complies with the health 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.

(14)(a) If a CMHC's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of a provider, the health records regarding recipients to whom the CMHC has provided services shall:

1. Remain the property of the CMHC; and
2. Be subject to the retention requirements established in subsection (4) of this section.

(b) A CMHC shall have a written plan addressing how to maintain health records in the event of a provider's death.

Section 8. Medicaid Program Participation Compliance. (1) A CMHC shall comply with:

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

(2)(a) If a CMHC receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the CMHC shall return the payment to the department or managed care organization that issued the duplicate payment or overpayment.

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

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

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

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

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

Section 11. Federal Approval and Federal Financial Participation. (1) The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

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

(2) The coverage of services provided by a licensed clinical alcohol and drug counselor or licensed clinical alcohol and drug counselor associate shall be contingent and effective upon approval by the Centers for Medicare and Medicaid Services.

Section 12. Appeal Rights. (1) An appeal of an adverse action by the department regarding 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.

Section 13. Incorporation by Reference. (1) The "Community Mental Health Center Behavioral Health Services Manual", May 2015, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at <http://www.chfs.ky.gov/dms/incorporated.htm>. (3 Ky.R. 641; eff. 2-2-1977; 5 Ky.R. 64; eff. 9-6-1978; 7 Ky.R. 861; eff. 6-3-1981; 8 Ky.R. 205; eff. 11-5-1981; Recodified from 904 KAR 1:044, 5-2-1986; 15 Ky.R. 2461; eff. 8-5-1989; 18 Ky.R. 915; eff. 10-16-1991; 20 Ky.R. 663; eff. 10-21-1993; 32 Ky.R. 1801; 2039; 2276; eff. 7-7-2006; 34 Ky.R. 1825; 2313; 2404; eff. 6-6-2008; 40 Ky.R. 1955; 2487; 2718; eff. 7-7-2014; 41 Ky.R. 1910; 2261; 2553; eff. 7-6-2015.)