

907 KAR 10:014. Outpatient hospital service coverage provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 447.53

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6310, 205.8453

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520 empowers 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 service and coverage policies for outpatient hospital services.

Section 1. Definitions. (1) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(2) "Approved behavioral health services provider" means:

- (a) A physician;
- (b) A psychiatrist;
- (c) An advanced practice registered nurse;
- (d) A physician assistant;
- (e) A licensed psychologist;
- (f) A licensed psychological practitioner;
- (g) A certified psychologist with autonomous functioning;
- (h) A licensed clinical social worker;
- (i) A licensed professional clinical counselor;
- (j) A licensed marriage and family therapist;
- (k) A licensed psychological associate;
- (l) A certified psychologist;
- (m) A marriage and family therapy associate;
- (n) A certified social worker;
- (o) A licensed professional counselor associate;
- (p) A licensed professional art therapist;
- (q) A licensed professional art therapist associate;
- (r) A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation;
- (s) A licensed clinical alcohol and drug counselor associate in accordance with Section 14 of this administrative regulation; or
- (t) A certified alcohol and drug counselor.

(3) "Behavioral health practitioner under supervision" means an individual who is:

- (a)1. A licensed professional counselor associate;
 - 2. A certified social worker;
 - 3. A marriage and family therapy associate;
 - 4. A licensed professional art therapist associate;
 - 5. A licensed assistant behavior analyst;
 - 6. A physician assistant;
 - 7. A certified alcohol and drug counselor; or
 - 8. A licensed clinical alcohol and drug counselor associate in accordance with Section 14 of this administrative regulation; and
 - (b) Employed by or under contract with the same billing provider as the billing supervisor.
- (4) "Billing provider" means the individual who, group of individual providers that, or organi-

zation that:

- (a) Is authorized to bill the department or a managed care organization for a service; and
- (b) Is eligible to be reimbursed by the department or a managed care organization for a service.

(5) "Billing supervisor" means an individual who is:

- (a)1. A physician;
- 2. A psychiatrist;
- 3. An advanced practice registered nurse;
- 4. A licensed psychologist;
- 5. A licensed clinical social worker;
- 6. A licensed professional clinical counselor;
- 7. A licensed psychological practitioner;
- 8. A certified psychologist with autonomous functioning;
- 9. A licensed marriage and family therapist;
- 10. A licensed professional art therapist; or
- 11. A licensed behavior analyst; and

(b) Employed by or under contract with the same billing provider as the behavioral health practitioner under supervision who renders services under the supervision of the billing supervisor.

(6) "Certified alcohol and drug counselor" is defined by KRS 309.080(2).

(7) "Certified psychologist" means an individual who is a certified psychologist pursuant to KRS 319.056.

(8) "Certified psychologist with autonomous functioning" means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.

(9) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(10) "Community support associate" means a paraprofessional who meets the application, training, and supervision requirements of 908 KAR 2:250.

(11) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

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

(13) "Electronic signature" is defined by KRS 369.102(8).

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

(15) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

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

(17) "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.

(18) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(19) "Individualized education program" is defined by 34 C.F.R. 300.320.

(20) "Licensed assistant behavior analyst" is defined by KRS 319C.010(7).

(21) "Licensed behavior analyst" is defined by KRS 319C.010(6).

(22) "Licensed clinical alcohol and drug counselor" is defined by KRS 309.080(4).

(23) "Licensed clinical alcohol and drug counselor associate" is defined by KRS 309.080(5).

(24) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

- (25) "Licensed marriage and family therapist" is defined by KRS 335.300(2).
- (26) "Licensed professional art therapist" is defined by KRS 309.130(2).
- (27) "Licensed professional art therapist associate" is defined by KRS 309.130(3).
- (28) "Licensed professional clinical counselor" is defined by KRS 335.500(3).
- (29) "Licensed professional counselor associate" is defined by KRS 335.500(4).
- (30) "Licensed psychological associate" means an individual who:
- (a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and
 - (b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.
- (31) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.
- (32) "Licensed psychologist" means an individual who:
- (a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and
 - (b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.
- (33) "Lock-in recipient" means:
- (a) A recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677; or
 - (b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 8.
- (34) "Marriage and family therapy associate" is defined by KRS 335.300(3).
- (35) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
- (36) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53.
- (37) "Peer support specialist" means an individual who meets the peer support specialist qualifications established in:
- (a) 908 KAR 2:220;
 - (b) 908 KAR 2:230; or
 - (c) 908 KAR 2:240.
- (38) "Person-centered service plan" means a plan of services for a recipient that meets the requirements established in 42 C.F.R. 441.540.
- (39) "Physician" is defined by KRS 205.510(11).
- (40) "Physician assistant" is defined by KRS 311.840(3).
- (41) "Provider" is defined by KRS 205.8451(7).
- (42) "Provider abuse" is defined by KRS 205.8451(8).
- (43) "Recipient" is defined by KRS 205.8451(9).
- (44) "Recipient abuse" is defined by KRS 205.8451(10).
- (45) "Recipient's representative" means:
- (a) For a recipient who is authorized by Kentucky law to provide written consent, an individual acting on behalf of, and with written consent from, the recipient; or
 - (b) A legal guardian.
- (46) "Section 504 plan" means a plan developed under the auspices of Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794 (Section 504), to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations to ensure the child's academic success and access to the learning environment.
- (47) "Unlisted procedure or service" means a procedure or service:
- (a) For which there is not a specific CPT code; and

(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Coverage Criteria. (1)(a) To be covered by the department, the following shall be prior authorized and meet the requirements established in paragraph (b) of this subsection:

1. Magnetic resonance imaging;
2. Magnetic resonance angiogram;
3. Magnetic resonance spectroscopy;
4. Positron emission tomography;
5. Cineradiography or videoradiography;
6. Xeroradiography;
7. Ultrasound subsequent to second obstetric ultrasound;
8. Myocardial imaging;
9. Cardiac blood pool imaging;
10. Radiopharmaceutical procedures;
11. Gastric restrictive surgery or gastric bypass surgery;
12. A procedure that is commonly performed for cosmetic purposes;
13. A surgical procedure that requires completion of a federal consent form; or
14. An unlisted procedure or service.

(b) To be covered by the department, an outpatient hospital service, including a service identified in paragraph (a) of this subsection, shall:

1. Be medically necessary;
2. Except for a behavioral health service established in Section 5 of this administrative regulation, be clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and
3. If provided to a lock-in recipient or enrollee, meet the requirements established in paragraph (c) of this subsection.

(c) If the lock-in recipient is:

1. Not an enrollee, the outpatient hospital service shall be:
 - a. Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or
 - b. A screening or emergency service that meets the requirements of subsection (6)(a) of this section; or
2. An enrollee, the outpatient hospital service shall be:
 - a. Provided by the enrollee's designated hospital as established by the managed care organization in which the enrollee is enrolled; or
 - b. A screening or emergency service that meets the requirements of subsection (6)(a) of this section.

(2)(a) The prior authorization requirements established in subsection (1) of this section shall not apply to:

1. An emergency service;
2. A radiology procedure if the recipient has a cancer or transplant diagnosis code; or
3. A service provided to a recipient in an observation bed.

(b) A behavioral health service established in Section 5 of this administrative regulation shall:

1. Be medically necessary; and
2. Not be subject to prior authorization.

(3) A referring physician, a physician who wishes to provide a given service, an advanced practice registered nurse, or a duly-licensed dentist may request prior authorization from the department.

(4) The following covered hospital outpatient services shall be furnished by or under the su-

pervision of a duly licensed physician, or, if applicable, a duly-licensed dentist:

- (a) A diagnostic service ordered by a physician;
 - (b) A therapeutic service;
 - (c) An emergency room service provided in an emergency situation as determined by a physician; or
 - (d) A drug, biological, or injection administered in the outpatient hospital setting.
- (5) A covered hospital outpatient service for maternity care may be provided by:
- (a) An advanced practice registered nurse who has been designated by the Kentucky Board of Nursing as a nurse midwife; or
 - (b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.
- (6) The department shall cover:
- (a) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or
 - (b) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

Section 3. Hospital Outpatient Services Not Covered by the Department. The following services shall not be considered a covered hospital outpatient service:

- (1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;
- (2) A service for which:
 - (a) An individual has no obligation to pay; and
 - (b) No other person has a legal obligation to pay;
- (3) A medical supply or appliance, unless it is incidental to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medicaid Program for hospital outpatient services;
- (4) A drug, biological, or injection purchased by or dispensed to a recipient;
- (5) A routine physical examination; or
- (6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:
 - (a) In an emergency department of a hospital; or
 - (b) If provided by a hospital that is not the lock-in recipient's designated hospital:
 - 1. Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or
 - 2. As established by the managed care organization in which the lock-in recipient is enrolled, if the lock-in recipient is an enrollee.

Section 4. Speech-language Pathology, Physical Therapy, and Occupational Therapy Limits. (1) Speech-language pathology services shall be limited to twenty (20) service visits per calendar year per recipient.

(2) Physical therapy services shall be limited to twenty (20) service visits per calendar year per recipient.

(3) Occupational therapy services shall be limited to twenty (20) service visits per calendar year per recipient.

(4) A service in excess of the limits established in subsection (1), (2), or (3) of this section shall be approved if the service in excess of the limits is determined to be medically necessary by the:

- (a) Department, if the recipient is not enrolled with a managed care organization; or
- (b) Managed care organization in which the enrollee is enrolled, if the recipient is an enrol-

lee.

(5) Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsection (1), (2), or (3) of this section for a recipient who is not enrolled with a managed care organization.

Section 5. Behavioral Health Services. (1) The following behavioral health services shall be covered under this administrative regulation in accordance with the following requirements:

(a) A screening, crisis intervention, or intensive outpatient program service provided by:

1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A certified psychologist with autonomous functioning;
4. A licensed clinical social worker;
5. A licensed professional clinical counselor;
6. A licensed professional art therapist;
7. A licensed marriage and family therapist;
8. A physician;
9. A psychiatrist;
10. An advanced practice registered nurse;
11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
12. A certified psychologist working under the supervision of a board-approved licensed psychologist;
13. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation; or
14. 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 psychological practitioner;
3. A certified psychologist with autonomous functioning;
4. A licensed clinical social worker;
5. A licensed professional clinical counselor;
6. A licensed professional art therapist;
7. A licensed marriage and family therapist;
8. A physician;
9. A psychiatrist;
10. An advanced practice registered nurse;
11. A licensed behavior analyst;
12. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
13. A certified psychologist working under the supervision of a board-approved licensed psychologist;
14. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation; or
15. A behavioral health practitioner under supervision;

(c) Psychological testing provided by:

1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A certified psychologist with autonomous functioning;

4. A licensed psychological associate working under the supervision of a board-approved licensed psychologist; or

5. A certified psychologist working under the supervision of a board-approved licensed psychologist;

(d) Day treatment or mobile crisis services provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

4. A licensed clinical social worker;

5. A licensed professional clinical counselor;

6. A licensed professional art therapist;

7. A licensed marriage and family therapist;

8. A physician;

9. A psychiatrist;

10. An advanced practice registered nurse;

11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;

12. A certified psychologist working under the supervision of a board-approved licensed psychologist;

13. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation;

14. A behavioral health practitioner under supervision, except for a licensed assistant behavior analyst; or

15. A peer support specialist working under the supervision of an approved behavioral health services provider;

(e) Peer support provided by a peer support specialist working under the supervision of an approved behavioral health services provider;

(f) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

4. A licensed clinical social worker;

5. A licensed professional clinical counselor;

6. A licensed professional art therapist;

7. A licensed marriage and family therapist;

8. A physician;

9. A psychiatrist;

10. An advanced practice registered nurse;

11. A licensed behavior analyst;

12. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;

13. A certified psychologist working under the supervision of a board-approved licensed psychologist;

14. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation; or

15. A behavioral health practitioner under supervision;

(g) Family outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;
3. A certified psychologist with autonomous functioning;
4. A licensed clinical social worker;
5. A licensed professional clinical counselor;
6. A licensed professional art therapist;
7. A licensed marriage and family therapist;
8. A physician;
9. A psychiatrist;
10. An advanced practice registered nurse;
11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
12. A certified psychologist working under the supervision of a board-approved licensed psychologist;
13. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation; or
14. A behavioral health practitioner under supervision, except for a licensed assistant behavior analyst;

(h) Service planning provided by:

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

(i) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:

1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A certified psychologist with autonomous functioning;
4. A licensed clinical social worker;
5. A licensed professional clinical counselor;
6. A licensed professional art therapist;
7. A licensed marriage and family therapist;
8. A physician;
9. A psychiatrist;
10. An advanced practice registered nurse;
11. A licensed psychological associate working under the supervision of a board-approved

licensed psychologist;

12. A certified psychologist working under the supervision of a board-approved licensed psychologist;

13. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation; or

14. A behavioral health practitioner under supervision, except for a licensed assistant behavior analyst;

(j) Assertive community treatment provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

4. A licensed clinical social worker;

5. A licensed professional clinical counselor;

6. A licensed professional art therapist;

7. A licensed marriage and family therapist;

8. A physician;

9. A psychiatrist;

10. An advanced practice registered nurse;

11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;

12. A certified psychologist working under the supervision of a board-approved licensed psychologist;

13. A behavioral health practitioner under supervision except for a:

a. Licensed assistant behavior analyst;

b. Certified alcohol and drug counselor; or

c. Licensed clinical alcohol and drug counselor associate;

14. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:

a. Licensed clinical alcohol and drug counselor;

b. Licensed clinical alcohol and drug counselor associate; or

c. Certified alcohol and drug counselor; or

15. A community support associate;

(k) Comprehensive community support services provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

4. A licensed clinical social worker;

5. A licensed professional clinical counselor;

6. A licensed professional art therapist;

7. A licensed marriage and family therapist;

8. A physician;

9. A psychiatrist;

10. An advanced practice registered nurse;

11. A licensed behavior analyst;

12. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;

13. A certified psychologist working under the supervision of a board-approved licensed psychologist;

14. A behavioral health practitioner under supervision except for a:

- a. Licensed clinical alcohol and drug counselor associate; or
- b. Certified alcohol and drug counselor; or
- 15. A community support associate;
- (l) Therapeutic rehabilitation program services provided by:
 - 1. A licensed psychologist;
 - 2. A licensed psychological practitioner;
 - 3. A certified psychologist with autonomous functioning;
 - 4. A licensed clinical social worker;
 - 5. A licensed professional clinical counselor;
 - 6. A licensed professional art therapist;
 - 7. A licensed marriage and family therapist;
 - 8. A physician;
 - 9. A psychiatrist;
 - 10. An advanced practice registered nurse;
 - 11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
 - 12. A certified psychologist working under the supervision of a board-approved licensed psychologist;
 - 13. A behavioral health practitioner under supervision except for a:
 - a. Licensed assistant behavior analyst;
 - b. Licensed clinical alcohol and drug counselor associate; or
 - c. Certified alcohol and drug counselor; or
 - 14. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - a. Licensed clinical alcohol and drug counselor;
 - b. Licensed clinical alcohol and drug counselor associate; or
 - c. Certified alcohol and drug counselor; or
- (m) Partial hospitalization 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 licensed psychological practitioner;
 - 9. A certified psychologist with autonomous functioning;
 - 10. A licensed clinical alcohol and drug counselor in accordance with Section 14 of this administrative regulation;
 - 11. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
 - 12. A certified psychologist working under the supervision of a board-approved licensed psychologist; or
 - 13. A behavioral health practitioner under supervision, except for a licensed assistant behavioral analyst.
- (2)(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 practitioner 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 the development of 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 plan of care; 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 outpatient hospital;
 - 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. Shall be followed by a referral to non-crisis services if applicable; and
 5. May include:
 - a. Further service prevention planning that includes:
 - (i) Lethal means reduction for suicide risk; or
 - (ii) Substance use disorder relapse prevention; or
 - b. Verbal de-escalation, risk assessment, or cognitive therapy.
 - (e) Mobile crisis services shall:
 1. Be available twenty-four (24) hours per day, seven (7) days per week, every day of the year;
 2. Ensure access to a board-certified or board-eligible psychiatrist, twenty-four (24) hours per day, seven (7) days per week, every day of the year;
 3. Be provided for a duration of less than twenty-four (24) hours;
 4. Not be an overnight service;
 5. Be a multi-disciplinary team-based intervention in a home or community setting that ensures access to mental health and substance use disorder services and supports to:
 - a. Reduce symptoms or harm; or
 - b. Safely transition an individual in an acute crisis to the appropriate least restrictive level of care;

6. Involve all services and supports necessary to provide:
 - a. Integrated crisis prevention;
 - b. Assessment and disposition;
 - c. Intervention;
 - d. Continuity of care recommendations; and
 - e. Follow-up services; and
7. Be provided face-to-face in a home or community setting.
 - (f)1. Day treatment shall be a non-residential, intensive treatment program for an individual 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 developmental 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 on non-instructional weekdays during the school year including scheduled school breaks;
 - (iii) In coordination with the recipient's individualized educational plan or Section 504 plan if the recipient has an individualized educational plan or Section 504 plan;
 - (iv) Under the supervision of a licensed or certified approved behavioral health services provider or a behavioral health practitioner working under clinical supervision; 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, an outpatient hospital 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.
 - (g)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 men-

tal 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

(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;

b. Be an evidence-based practice;

c. Be structured and scheduled non-clinical 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 contribute directly to the recipient's individualized goals as specified in the recipient's plan of care.

2. To provide peer support services, an outpatient hospital 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 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;

c. Use an approved behavioral health services provider to supervise peer support specialists;

d. Have the capacity to coordinate the provision of services among team members; and

e. Have the capacity to provide on-going continuing education and technical assistance to peer support specialists.

(h)1. Intensive outpatient program services shall:

a. Be an alternative to or transition from inpatient hospitalization or partial hospitalization for a mental health disorder, substance use disorder, or co-occurring disorders;

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, group outpatient therapy, or family outpatient therapy unless contraindicated;

(ii) Crisis intervention; or

(iii) 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, an outpatient hospital shall have:
 - a. Access to a board-certified or board-eligible psychiatrist for consultation;
 - b. Access to a psychiatrist, physician, or advanced practice registered nurse for medication prescribing and monitoring;
 - c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one (1) staff person;
 - d. The capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles; and
 - e. 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.
 - (i) 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 unless additional time is medically necessary.
 - (j)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;
 - 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 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 relate to each recipient participating in the

group.

4. The provider shall keep individual notes regarding each recipient of the group and within each recipient's health record.

(k)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 well-being of the recipient; or

(ii) Recipient's recovery from a substance use disorder, mental health disorder, or co-occurring mental health and substance use disorders; and

b. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

(l)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, a recipient's representative, school staff person, 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 given 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.

(m)1. Service planning shall:

a. Involve assisting a recipient in creating an individualized plan for services needed for maximum reduction of the effects 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:

(i) Recipient; or

(ii) Recipient's representative if the recipient is under the age of eighteen (18) years or is unable to provide direction;

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.

(n) 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 in order 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 additional services to address the recipient's substance use.

(o)1. Assertive community treatment shall:

a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a severe mental illness; and

b. Include:

- (i) Assessment;
- (ii) Treatment planning;
- (iii) Case management;
- (iv) Psychiatric services;
- (v) Medication prescribing and monitoring;
- (vi) Individual outpatient therapy;
- (vii) Group outpatient therapy;
- (viii) Mobile crisis services;
- (ix) Mental health consultation;
- (x) Family support and basic living skills; or
- (xi) Peer support.

2.a. Mental health consultation shall involve brief, collateral interactions with other treating professionals who may have information for the purpose of treatment planning and service delivery.

b. Family support shall involve the assertive community treatment team's working with the recipient's natural support systems to improve family relations in order to:

- (i) Reduce conflict; and
- (ii) Increase the recipient's autonomy and independent functioning.

c. Basic living skills shall be rehabilitative services focused on teaching activities of daily living necessary to maintain independent functioning and community living.

3. To provide assertive community treatment services, an outpatient hospital shall:

a. Employ at least one (1) team of multidisciplinary professionals:

(i) Led by an approved behavioral health services provider except for a licensed clinical alcohol and drug counselor, a licensed clinical alcohol and drug counselor associate, or a certified alcohol and drug counselor; and

(ii) Comprised of at least four (4) full-time equivalents including a psychiatrist, a nurse, a case manager, a peer support specialist, or an approved behavioral health services provider except for a licensed clinical alcohol and drug counselor, a licensed clinical alcohol and drug counselor associate, or a certified alcohol and drug counselor;

b. Have adequate staffing to ensure that no team's caseload size exceeds ten (10) participants per team member (for example, if the team includes five (5) individuals, the caseload for the team shall not exceed fifty (50) recipients);

c. Have the capacity to:

- (i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;
- (ii) Coordinate the provision of services among team members;
- (iii) Provide the full range of assertive community treatment services as stated in this para-

graph; and

(iv) Document and maintain individual health records; and

d. Demonstrate experience in serving individuals with persistent and severe mental illness who have difficulty living independently in the community.

(p)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 rehabilitation techniques to:

(i) Improve daily living skills;

(ii) Improve self-monitoring of symptoms and side effects;

(iii) Improve emotional regulation skills;

(iv) Improve crisis coping skills; and

(v) Develop and enhance interpersonal skills.

2. To provide comprehensive community support services, an outpatient hospital 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 (1)(k) 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.

(q)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 the effects 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 person-centered service plan.

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 skill; and

(v) Interpersonal skills; and

c. Be delivered individually or in a group.

(r)1. Partial hospitalization shall be a short-term (average of four (4) to six (6) weeks), less than twenty-four (24)-hour, intensive treatment program for an individual who is experiencing significant impairment to daily functioning due to a substance use disorder, a mental health disorder, or co-occurring mental health and substance use disorders.

2. Partial hospitalization may be provided to an adult or a child.

3. Admission criteria for partial hospitalization shall be based on an inability to adequately treat the recipient through community-based therapies or intensive outpatient services.

4. A partial hospitalization program shall consist of individual outpatient therapy, group outpatient therapy, family outpatient therapy, or medication management.

5.a. The department shall not reimburse for educational, vocational, or job training services

provided as part of partial hospitalization.

b. An outpatient hospital's partial hospitalization program shall have an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable.

c. The department shall not reimburse for services identified in a Medicaid-eligible child's individualized education program.

6. Partial hospitalization shall typically be:

a. Provided for at least four (4) hours per day; and

b. Focused on one (1) primary presenting problem (i.e. substance use, sexual reactivity, or another problem).

7. An outpatient hospital's partial hospitalization program shall:

a. Include the following personnel for the purpose of providing medical care if necessary:

(i) An advanced practice registered nurse;

(ii) A physician assistant or physician available on site; and

(iii) A board-certified or board-eligible psychiatrist available for consultation; and

b. Have the capacity to:

(i) Provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles;

(ii) Employ required practitioners and coordinate service provision among rendering practitioners; and

(iii) Provide the full range of services included in the scope of partial hospitalization established in this subsection.

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

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

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

(6) A behavioral health service shall be:

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

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

(7)(a) An outpatient hospital shall establish a plan of care for each recipient receiving behavioral health services from the outpatient hospital.

(b)1. For a recipient receiving intensive outpatient program services, the recipient's plan of care shall be:

a. Reviewed every thirty (30) days; and

b. Updated every sixty (60) days or earlier if clinically indicated.

2. For a recipient receiving behavioral health services other than intensive outpatient program services, the recipient's plan of care shall be reviewed and updated every six (6) months or earlier if clinically indicated.

Section 6. Additional Behavioral Health Service Limits and Non-covered Behavioral Health Services or Activities. (1)(a) Except as established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the recipient's health 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. Mobile crisis services;

2. Crisis intervention;

3. A screening; or
4. An assessment.

(2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same period of time in which the recipient receives assertive community treatment:

- (a) An assessment;
- (b) Case management;
- (c) Individual outpatient therapy;
- (d) Group outpatient therapy;
- (e) Peer support services; or
- (f) Mobile crisis services.

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

(4) 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 outpatient hospital;

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

(d) 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" established in Section 1(17) of this administrative regulation;

(e) Travel time;

(f) A field trip;

(g) A recreational activity;

(h) A social activity; or

(i) A physical exercise activity group.

(5)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as established in Section 5(2)(l)1 of this administrative regulation.

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

(6) 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.

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

1. Collateral outpatient therapy for a recipient under the age of twenty-one (21) years if the collateral outpatient therapy is in the recipient'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 behavioral health service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

Section 7. 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 during the same time period.

(2) For example, if a recipient is receiving speech-language pathology services from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech-language pathology services provided to the same recipient during the same time period via the outpatient hospital services program.

Section 8. General Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. 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.

2. 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.

(2)(a) Except as established in paragraph (b) or (c) of this subsection, an outpatient hospital shall maintain a health record regarding a recipient for at least six (6) years from the last 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 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.

(3)(a) A provider shall comply with 45 C.F.R. Part 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 outpatient hospital 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 managed care organization.

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.

(4)(a) If an outpatient hospital'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 an owner or deaths of owners, the health records of the outpatient hospital shall:

1. Remain the property of the outpatient hospital; and
2. Be subject to the retention requirements established in this section.

(b) An outpatient hospital shall have a written plan addressing how to maintain health records in the event of death of an owner or deaths of owners.

Section 9. Additional Requirements Regarding Behavioral Health Services Health Records.

(1) The requirements established in this section shall apply to a health record regarding a behavioral health service.

(2) A health record regarding a recipient who received a behavioral health service 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 or Medicaid participation 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 outpatient hospital in order to comply with the requirements of:

(i) This administrative regulation;

(ii) The outpatient hospital's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening;

b. Assessment if an assessment was performed; and

c. Disposition if a disposition was performed;

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:
 - a. To the Cabinet for Health and Family Services; or
 - b. For an enrollee, to the 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.
 - (3) 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.
 - (4)(a) An outpatient hospital'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 behavioral health practitioner working under supervision shall be co-signed and dated by the supervising professional within thirty (30) days.
 2. If services are provided by a behavioral health practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional which reflects consultations with the behavioral health practitioner working under supervision concerning the:
 - a. Case; and
 - b. Supervising professional's evaluation of the services being provided to the recipient.
 - (5) Immediately following a screening of a recipient, the practitioner 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.
 - (6) 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.
 - (7)(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 practitioner 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 non-reimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(8)(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

c. Individual's condition upon termination and disposition.

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

(9) 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.

(10)(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 outpatient hospital shall, within ten (10) business days of awareness 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.

(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 outpatient hospital 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.

Section 10. Medicaid Program Participation Compliance. (1) A provider 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 provider receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the provider shall return the payment to the

department or managed care organization in accordance with 907 KAR 1:671.

(b) Failure to return a payment to the department or managed care organization 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.

(3)(a) When the department or a managed care organization makes payment for a covered service and the outpatient hospital 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 outpatient hospital.

(b)1. An outpatient hospital 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. Outpatient hospital makes the recipient aware in writing 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. Outpatient hospital shall not bill the department or managed care organization for the service; and

b. Department or managed care organization shall not:

- (i) Be liable for any part of the payment associated with the service; and
- (ii) Make any payment to the outpatient hospital regarding the service.

(c) Except as established in paragraph (b) of this subsection or except for a cost sharing obligation owed by a recipient, a provider shall not bill a recipient for any part of a service provided to the recipient.

(4)(a) An outpatient hospital shall attest by the outpatient hospital's staff's or representative's signature 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;
5. United States General Accounting Office or its designee; or
6. For an enrollee, managed care organization in which the enrollee is enrolled.

(c)1. If an outpatient hospital receives a request from the:

a. Department to provide a claim, related information, related documentation, or record for auditing purposes, the outpatient hospital shall provide the requested information to the department within the timeframe requested by the department; or

b. Managed care organization in which an enrollee is enrolled to provide a claim, related information, related documentation, or record for auditing purposes, the outpatient hospital shall provide the requested information to the managed care organization within the timeframe requested by the managed care organization.

2.a. The timeframe requested by the department or managed care organization for an outpatient hospital to provide requested information shall be:

- (i) A reasonable amount of time given the nature of the request and the circumstances sur-

rounding the request; and

(ii) A minimum of one (1) business day.

b. An outpatient hospital may request a longer timeframe to provide information to the department or a managed care organization if the outpatient hospital justifies the need for a longer timeframe.

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

2. Willful abuse by an outpatient hospital shall result in the suspension or termination of the outpatient hospital from Medicaid Program participation.

Section 11. Third Party Liability. A provider shall comply with KRS 205.622.

Section 12. 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) A provider 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 or her responsibility in allowing the use of the electronic signature; and

(c) 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 13. 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 any claim or health record.

Section 14. 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 15. Appeal Rights. (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. (2 Ky.R. 102; eff. 9-10-1975; 3 Ky.R.

765; eff. 7-6-1977; 11 Ky.R. 1941; eff. 7-9-1985; Recodified from 904 KAR 1:014, 5-2-1986; Am. 17 Ky.R. 557; eff. 10-14-1990; 33 Ky.R. 578; 1550; eff. 1-5-2007; 37 Ky.R. 984; eff. 11-05-2010; Recodified from 907 KAR 1:014, eff. 5-3-2011; TAm eff. 7-16-2013; 40 Ky.R. 2009; 2554; 2771; eff. 7-7-2014; 41 Ky.R. 2428; 42 Ky.R. 406; 741; eff. 10-2-2015; TAm eff. 2-9-2016.)