CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended After Comments)

907 KAR 3:170. Telehealth service coverage and reimbursement.

RELATES TO: KRS 194A.060, 205.510(16), (17), 205.559, 205.5591, 205.560, 304.38-240, 422.317, 434.840-434.860, 42 C.F.R. 400.203, 415.174, 415.184, 431.300-431.307, 440.50, Part 455, 45 C.F.R. 164.530, 42 U.S.C. 1395m

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559, 205.5591, 205.560

NECESSITY, FUNCTION, AND CONFORMITY: In accordance with KRS 194A.030(2), the Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. KRS 205.559 establishes the requirements regarding Medicaid reimbursement of telehealth providers, and KRS 205.5591 requires the cabinet to promulgate an administrative regulation relating to telehealth services and reimbursement. This administrative regulation establishes the Department for Medicaid Services' coverage and reimbursement policies relating to telehealth services in accordance with KRS 205.559 and 205.5591.

Section 1. Definitions.

(1) "Asynchronous telehealth" means a store and forward telehealth service that is electronically mediated.

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

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

(4) "In-person" means a healthcare encounter occurring:

(a) Via direct contact and interaction between the individual and healthcare provider;

(b) At the same location; and

(c) Not via telehealth.

(5) "Medical necessity" or "medically necessary" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130 or pursuant to the process established by KRS 304.38-240.

(6) "Place of service" means anywhere the patient is located at the time a telehealth service is provided, and includes telehealth services provided to a patient located at the patient's home or office, or a clinic, school, or workplace.

(7) "Remote patient monitoring" means a digital technology that collects medical and health data from an individual in one (1) location and electronically and securely transmits that data to a telehealth care provider in a different location.

(8) "Synchronous telehealth" means a telehealth service that simulates an in-person encounter via real-time interactive audio and video technology between a telehealth care provider and a Medicaid recipient.

(9) "Telehealth" is defined by KRS 205.510(16).

(10) "Telehealth care provider" means a Medicaid provider who is:

(a)

1. Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672;

2. Currently participating as a Medicaid provider in accordance with 907 KAR 1:671;

3. Operating within the scope of the provider's professional licensure; and

4. Operating within the provider's scope of practice; or

(b) A community mental health center (CMHC) that is participating in the Medicaid program in compliance with 907 KAR 1:044, 907 KAR 1:045, or 907 KAR 1:047.

(11) "Telehealth service" means any service that is provided by telehealth and is one (1) of the following:

(a) Event;

(b) Encounter;

(c) Consultation, including a telehealth consultation as defined by KRS 205.510(17);

(d) Visit;

(e) Store and forward transfer, as limited by Section 6 of this administrative regulation;

(f) Remote patient monitoring;

(g) Referral; or

(h) Treatment.

Section 2. Recipient Right to Receive Care In-Person or Via Synchronous Telehealth.

(1) Any recipient, upon being offered the option of an asynchronous or audio-only telehealth visit, shall have the opportunity or option to request to be accommodated by that provider in an in-person encounter or synchronous telehealth encounter.

(2)

(a) A telehealth care provider that has received a request for an in-person encounter or synchronous telehealth encounter shall provide an alternative in-person or synchronous telehealth encounter for the recipient within:

1. A reasonable time;

2. The existing availability constraints of the provider's schedule; and

3. No more than three (3) weeks of the recipient's request, unless the recipient's condition or described symptoms suggest a need for an earlier synchronous or in-person encounter.

(b)

1. A provider's failure to accommodate a recipient with a synchronous telehealth or in-person encounter shall be reported to the Office of the Ombudsman and Administrative Review of the Cabinet for Health and Family Services, or its successor organization by a:

a. Recipient;

b. Recipient's guardian or representative;

c. Another provider; or

d. Managed care organization.

2. The Office of the Ombudsman and Administrative Review shall investigate as appropriate and forward reports of a failure to accommodate to the department.

(c) If a provider fails to accommodate any recipient or combination of recipients ten (10) or more times within a calendar year, the department may:

1. Issue a corrective action plan to ensure that recipients are receiving appropriate and timely care.

2. Suspend the provider from providing asynchronous telehealth services to Medicaid recipients.

(d) The requirement to accommodate established in this subsection shall not apply to a provider who is participating in the encounter only to diagnose or evaluate an image or data file.

(e) A request for an in-person or synchronous encounter shall be recorded within the recipient's medical record.

Section 3. General Policies.

(1)

(a) The telehealth policies established in this administrative regulation shall supersede any in-person requirement established within KAR Title 907.
(b) The requirement established in paragraph (a) of this subsection shall not supersede an in-person requirement established pursuant to:
1. State or federal law, including via the state plan or a waiver;
2. A standard set by a professional criteria, such as the American Society of Addiction Medicine's (ASAM) Criteria, if applicable;
3. A licensing body; or
4. A billing code requirement established pursuant to a department utilized procedure code.
(2) Subject to any relevant restrictions in this administrative regulation, a telehealth service shall be reimbursable if it is:
(a) Appropriate and safe to be delivered via the telecommunication technology used. For the purposes of this section, whether a service is appropriate shall include any requirements and descriptions relating to a department utilized procedure code;
(b) Not prohibited by the licensing board of the telehealth care provider delivering or supervising the service; and
(c) Provided by a telehealth care provider.
(3) Unless prohibited by the relevant licensing board of the telehealth care provider, a telehealth care provider may establish a new patient and conduct an initial visit with the new patient via the use of synchronous telehealth.
(4)
(a) Except as provided in paragraph (b) of this subsection, the coverage policies established in this administrative regulation shall apply to:
1. Medicaid services for individuals not enrolled in a managed care organization; and
2. A managed care organization's coverage of Medicaid services for individuals enrolled in the managed care organization for the purpose of receiving Medicaid or Kentucky Children's Health Insurance Program services.
(b) A managed care organization shall reimburse the same amount for a telehealth service as the department reimburses unless a different payment rate is negotiated in accordance with Section 4(1)(a) of this administrative regulation.
(5) A telehealth service shall not be reimbursed by the department if:
(a) It is not medically necessary;
(b) The equivalent service is not covered by the department if provided in an in-person setting; or
(c) The telehealth care provider of the telehealth service is:
1. Not currently enrolled in the Medicaid program pursuant to 907 KAR 1:672;
2. Not currently participating in the Medicaid program pursuant to 907 KAR 1:671;
3. Not in good standing with the Medicaid program;
4. Currently listed on the Kentucky DMS Provider Terminated and Excluded Provider List, which is available at https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/terminated.aspx;
5. Currently listed on the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities, which is available at https://oig.hhs.gov/exclusions/;
6. Not otherwise prohibited from participating in the Medicaid program in accordance with 42 C.F.R. 455; or
7. Not physically located within the United States or a United States territory at the time of service.
(6)
(a) A telehealth service shall be subject to utilization review for:

1. Medical necessity;
2. Compliance with this administrative regulation; and
3. Compliance with applicable state and federal law.

(b) The department shall not reimburse for a telehealth service if the department determines that a telehealth service is not:

1. Medically necessary:
2. Compliant with this administrative regulation;
3. Applicable to this administrative regulation; or
4. Compliant with applicable state or federal law.

(c) The department shall recover the paid amount of a reimbursement for a previously reimbursed telehealth service if the department determines that a telehealth service was not:

1. Medically necessary;
2. Compliant with this administrative regulation;
3. Applicable to this administrative regulation; or
4. Compliant with applicable state or federal law.

(7)

(a) If a telehealth service is delivered as an audio-only encounter and a telephonic code exists for the same or similar service, the department shall reimburse at the lower reimbursement rate between the two (2) types of services.

(b) An attempted and scheduled telehealth service that is completed telephonically due to provider or recipient technological failure shall be reimbursed at the reimbursement rate of the telehealth encounter.

(8) A telehealth service shall have the same referral requirements as an in-person service.

(9) Within forty-eight (48) hours of the reconciliation of the record of the telehealth service, a provider shall document within the patient's medical record that a service was provided via telehealth, and follow all documentation requirements established by Section 5 of this administrative regulation.

(10) Pursuant to 907 KAR 1:671 and 1:672, the department shall require a telehealth care provider to meet all relevant licensure and accreditation requirements that would be required for that provider to provide care to a recipient in an in-person setting.

Section 4. Telehealth Reimbursement.

(1)

(a) The department shall reimburse an eligible telehealth care provider for a telehealth service in an amount that is at least 100 percent of the amount paid for a comparable in-person service.

(b) A managed care organization and provider may establish a different rate for telehealth reimbursement via contract as allowed pursuant to KRS 205.5591(2)(a)1..

(2) A provider shall appropriately denote telehealth services by place of service or other means as designated by the department or as required in a managed care organization's contract with the provider or member.

(3)

(a) Pursuant to KRS 205.559(2)(a)1., the department shall reimburse an originating site fee for a qualifying Medicare-participating telehealth care provider if the Medicaid beneficiary served was physically located at a rural health clinic, federally qualified health center, or federally qualified health center look-alike when the telehealth service was performed.

(b) The payment for an originating site facility fee shall be consistent with the amounts established in 42 U.S.C. 1395m(m)(2)(B)(i).

Section 5. Telehealth Provided by an Out-of-State Telehealth Care Provider.

(1) The department shall evaluate and monitor the healthcare quality and outcomes for recipients who are receiving healthcare services from out-of-state telehealth care providers.
(2) The department shall implement any in-state or out-of-state participation restrictions established by a state licensing board for the impacted provider .
(3) In order to improve healthcare quality and outcomes for recipients, the department may:
(a) Require a telehealth care provider who is located out-of-state to practice under an agreement with a provider with a physical presence within Kentucky.
(b) Prohibit certain services, recipients, or providers from conducting telehealth services if those services are provided by a telehealth care provider located out-of-state.

Section 6. Asynchronous Telehealth.
(1) An asynchronous telehealth service or store and forward transfer shall be limited to those telehealth services that have an evidence base establishing the service's safety and efficacy.
(2) A store and forward service shall be permissible if the primary purpose of the asynchronous interaction involves high quality digital data transfer, such as digital image transfers. An asynchronous telehealth service within the following specialties or instances of care that meets the criteria established in this section shall be reimbursable as a store and forward telehealth service:
(a) Radiology;
(b) Cardiology;
(c) Oncology;
(d) Obstetrics and gynecology;
(e) Ophthalmology and optometry, including a retinal exam;
(f) Dentistry;
(g) Nephrology;
(h) Infectious disease;
(i) Dermatology;
(j) Orthopedics;
(k) Wound care consultation;
(l) A store and forward telehealth service in which a clear digital image is integral and necessary to make a diagnosis or continue a course of treatment;
(m) A speech language pathology service that involves the analysis of a digital image, video, or sound file, such as for a speech language pathology diagnosis or consultation; or
(n) Any code or group of services included as an allowed asynchronous telehealth service pursuant to subsection (4) of this section.
(3) Unless otherwise prohibited by this section, an asynchronous telehealth service shall be reimbursable if that service supports an upcoming synchronous telehealth or in-person visit to a provider that is providing one (1) of the specialties or instances of care listed in subsection (2) of this section.
(4)
(a) The department shall evaluate available asynchronous telehealth services quarterly, and may clarify that certain asynchronous telehealth services meet the requirements of this section to be included as permissible asynchronous telehealth, as appropriate and as funds are available, if those asynchronous telehealth services have an evidence base establishing the service's:
1. Safety; and
2. Efficacy.

(b) Any asynchronous service that is determined by the department to meet the criteria established pursuant to this subsection shall be available on the department's Web site.

(5) Except as allowed pursuant to subsection (4) of this section or otherwise within the Medicaid program, a provider shall not receive additional reimbursement for an asynchronous telehealth service if the service is an included or integral part of the billed office visit code or service code.

(6) Pursuant to Section 7 of this administrative regulation, remote patient monitoring shall be an eligible telehealth service within the fee-for-service and managed care Medicaid programs.

(7) Each asynchronous telehealth service shall involve timely actual input and responses from the provider, and shall not be solely the result of reviewing an artificial intelligence messaging generated interaction with a recipient.

Section 7. Remote Patient Monitoring.

(1) Conditions for which remote patient monitoring shall be covered include:

(a) Pregnancy;

(b) Diabetes;

(c) Heart disease;

(d) Cancer;

(e) Chronic obstructive pulmonary disease;

(f) Hypertension;

(g) Congestive heart failure;

(h) Mental illness or serious emotional disturbance;

(i) Myocardial infarction;

(j) Stroke; or

(k) Any condition that the department determines would be appropriate and effective for remote patient monitoring.

(2) Except for a recipient participating due to a pregnancy, a recipient receiving remote patient monitoring services shall have two (2) or more of the following risk factors:

(a) Two (2) or more inpatient hospital stays during the prior twelve (12) month period;

(b) Two (2) or more emergency department admissions during the prior twelve (12) month period;

(c) An inpatient hospital stay and a separate emergency department visit during the prior twelve (12) month period;

(d) A documented history of poor adherence to ordered medication regimens;

(e) A documented history of falls in the prior six (6) month period;

(f) Limited or absent informal support systems;

(g) Living alone or being home alone for extended periods of time;

(h) A documented history of care access challenges; or

(i) A documented history of consistently missed appointments with health care providers.

(3) A recipient may participate in a remote patient monitoring program as the result of a pregnancy if the provider documents that the recipient has a condition that would be improved by a remote patient monitoring service.

(4) Remote patient monitoring shall be ordered by:

(a) A physician;

(b) An advanced practice registered nurse;

(c) A physician's assistant; or

(d) When operating within their scope of practice and licensure, the following behavioral health practitioners:

1. A psychiatrist;

2. A licensed psychologist;

3. A licensed psychological practitioner;
4. A certified psychologist with autonomous functioning;
5. A licensed clinical social worker;
6. A licensed marriage and family therapist;
7. A licensed professional art therapist;
8. A licensed clinical alcohol and drug counselor; or
9. A licensed behavior analyst.

(5) Providers who may provide remote patient monitoring services include:

(a) A home health agency;
(b) A hospital;
(c) A federally qualified health center;
(d) A rural health center;
(e) A primary care center;
(f) A physician;
(g) An advanced practice registered nurse;
(h) A physician's assistant;
(i) A behavioral health multi-specialty group participating in the Medicaid program pursuant to 907 KAR 15:010;
(j) A behavioral health services organization participating in the Medicaid program pursuant to 907 KAR 15:020 or 907 KAR 15:022;
(k) A residential crisis stabilization unit participating in the Medicaid program pursuant to 907 KAR 15:070;
(l) A chemical dependency treatment center participating in the Medicaid program pursuant to 907 KAR 15:080;
(m) A community mental health center that is participating in the Medicaid program in compliance with 907 KAR 1:044, 907 KAR 1:045, or 907 KAR 1:047; or
(n) A certified community behavioral health clinic that is participating in the Medicaid program.

(6) A recipient participating in a remote patient monitoring service shall:

(a) Have the capability to utilize any monitoring tools involved with the ordered remote patient monitoring service. For the purposes of this paragraph, capability shall include the regular presence of an individual in the home who can utilize the involved monitoring tools; and
(b) Have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.

(7) The department may restrict the remote patient monitoring benefit by excluding:

(a) Remote patient monitoring equipment;
(b) Upgrades to remote patient monitoring equipment; or
(c) An internet connection necessary to transmit the results of the services.

Section 8. Telephonic Services. Telephonic code reimbursement shall be:

(1) An alternative option for telehealth care providers to deliver audio-only telecommunications services, and shall not supersede reimbursement for an audio-only telehealth service as established pursuant to KRS 205.559 or 205.5591;
(2) For a service that has an evidence base establishing the service's safety and efficacy;
(3) Subject to any relevant licensure board restrictions of the telehealth care provider;
(4) Subject to any synchronous telehealth limits of this administrative regulation or other state or federal law; and
(5) For a service that is listed on the most recent version of the Physician Fee Schedule.

Section 9. Department Maintained List.

(1) In order to assist with the effective and appropriate delivery of services, the department may establish and maintain an informational listing of procedure codes that

are:

(a) Not allowed to be provided via telehealth due to conflicts with the requirements established within state or federal law, or this administrative regulation; or

(b) Subject to additional restrictions related to telehealth, such as a requirement that any telehealth associated with a procedure be conducted via a connection that has both video and audio of the recipient and provider.

(2) Any informational listing shall be available on the department's Web site.

Section 10. Medical Records.

(1) A medical record of a telehealth service shall be maintained in compliance with 907 KAR 1:672 and 45 C.F.R. 164.530(j).

(2) A health care provider shall have the capability of generating a hard copy of a medical record of a telehealth service.

Section 11. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the policy; or

(2) Disapproves the policy.

Section 12. Appeal Rights.

(1) An appeal of a department determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

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

(3) A provider may appeal a department-written determination as to the application of this administrative regulation in accordance with 907 KAR 1:671.

(4) An appeal of a managed care organization's determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 17:010.

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

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