CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(Amendment)

907 KAR 10:016. Coverage provisions and requirements regarding inpatient psychiatric hospital services.

RELATES TO: KRS 205.520
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441 Subparts C, D, 456 Subparts D, G, H, I, 42 U.S.C. 1396a-d
CERTIFICATION STATEMENT:
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding inpatient services provided by psychiatric hospitals.

Section 1. Definitions.
(1) "Active treatment" means a covered psychiatric hospital service provided:
(a) In accordance with 42 C.F.R. 441.154; and
(b) By professional staff employed or contracted by a psychiatric hospital.
(2) "Chronic" is defined by KRS 210.005(2).
(3) "Department" means the Department for Medicaid Services or its designee.
(4) "Enrollee" means a recipient who is enrolled with a managed care organization.
(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(6) "Interdisciplinary team" means:
(a) For a recipient who is under the age of eighteen (18) years:
1. A parent, legal guardian, or caregiver of the recipient;
2. The recipient;
3. Professional staff; and
4. A staff person, if available, who worked with the recipient during the recipient's most recent placement if the recipient has previously been in a psychiatric hospital; or
(b) For a recipient who is eighteen (18) years of age or older:
1. The recipient;
2. Professional staff;
3. A staff person, if available, who worked with the recipient during the recipient's most recent placement if the recipient has previously been in a psychiatric hospital; and
4. If requested by the recipient, a parent, legal guardian, or caregiver of the recipient.
(7) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.
(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(9) "Mental illness" is defined by KRS 210.005(5).
(10) "Professional staff" means psychiatrists and other physicians, physician assistants, psychologists, psychiatric nurses and other nurses, social workers, and other professionals with special education or experience in the care of persons with mental

illness and who are involved in the diagnosis and treatment of patients with mental illness.

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

Section 2. General Provider Participation Requirements.

(1) To be eligible to provide services covered under this administrative regulation, a psychiatric hospital shall:

(a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, be currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;

(c) Be licensed as a psychiatric hospital in accordance with 902 KAR 20:180;

(d) Meet the facility specification requirements established in 902 KAR 20:170;

(e) Have a utilization review plan for each recipient;

(f) Establish a utilization review process which shall evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;

(g) Be located:

1. Within the Commonwealth of Kentucky;
2. In a state contiguous to the Commonwealth of Kentucky; or
3. In a non-contiguous state and participates on a time-limited, case-by-case basis. The department may limit placement to hospitals within a non-contiguous state to urgent cases who are not able to be placed within the commonwealth or a contiguous state.

(h) Perform and place in each recipient's record a:

1. Medical evaluation;
2. Social evaluation; and
3. Psychiatric evaluation;

(i) Establish a plan of care for each recipient which shall:

1. Address in detail the intensive treatment services to be provided to the recipient;
2. Be placed in the recipient's record; and
3. Meet the master treatment plan requirements established in 902 KAR 20:180; and

(j) If providing services to an individual who is at least sixty-five (65) years of age, be currently certified for participation in the Medicare program.

(2) In accordance with 907 KAR 17:015, Section 3(3), a psychiatric hospital which provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(3) A psychiatric hospital shall:

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

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

(c) Comply with:

1. 907 KAR 1:671;
2. 907 KAR 1:672; and
3. All applicable state and federal laws.

(4)

(a) A psychiatric hospital shall attest by the psychiatric 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) If a psychiatric hospital receives a request from the:

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

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

(d)

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

2. Willful abuse by a psychiatric hospital provider shall result in the suspension or termination of the psychiatric hospital from Medicaid Program participation.

Section 3. Coverage Requirements.

(1) For the department or managed care organization to reimburse for a service covered under this administrative regulation, the service shall be:

(a) Medically necessary; and

(b) Provided:

1. To a recipient:

a.

(i) Who is at least sixty-five (65) years of age and requires inpatient psychiatric services; or

(ii) Who is under twenty-one (21) years of age and requires inpatient psychiatric services; and

b. Whose needs require inpatient psychiatric hospital services:

(i) On a daily basis; and

(ii) Under the direction of a physician; and

2. By professional staff of a psychiatric hospital that meets the requirements established in this administrative regulation.

(2) Inpatient psychiatric hospital services shall involve active treatment that shall be reasonably expected to:

(a) Improve the recipient's condition; or

(b) Prevent further regression.

(3) If a recipient is receiving inpatient psychiatric hospital services on the recipient's twenty-first (21st) birthday, the Medicaid Program shall continue to cover the recipient's admission:

(a) As long as the services continue to be medically necessary for the recipient; and

(b) Through the birth month in which the child becomes twenty-two (22) years of age.

(4)

(a) If a recipient is eligible for Medicare coverage of inpatient psychiatric services, the recipient shall exhaust all Medicare coverage of inpatient psychiatric services prior to being eligible for Medicaid coverage of inpatient psychiatric services.

(b) After exhausting Medicare coverage of inpatient psychiatric services, the department, or managed care organization for an enrollee, shall determine if a continued stay in a psychiatric hospital:

1. Is medically necessary for the recipient; and
2. Can be reasonably expected to:
a. Improve the recipient's condition; or
b. Prevent further regression.

(5) The requirements established in 42 C.F.R. 456, Subpart D (456.150 to 456.245), shall apply regarding Medicaid program coverage of inpatient psychiatric hospital services.

Section 4. KRS Chapter 202A Related Admission.

(1) For an adult who is at least sixty-five (65) years of age, has chronic mental illness, and is admitted to a psychiatric hospital under a KRS Chapter 202A commitment, the psychiatric hospital shall maintain the recipient at, or restore the recipient to, the greatest possible degree of health and independent functioning.

(2) For a recipient who was at least sixty-five (65) years of age and residing in a psychiatric hospital on December 28, 1994, the requirement for admission under a commitment pursuant to KRS Chapter 202A shall not apply if:

(a) The recipient continues to reside in the same psychiatric hospital; and

(b) Ambulatory care or alternative services available in the community are not sufficient to meet the treatment needs of the recipient.

Section 5. Reevaluation of Need for Services.

(1)

(a) A psychiatric hospital stay shall be certified for a specific length of time as deemed medically appropriate by the:

1. Department for a recipient who is not an enrollee; or
2. Managed care organization in which an enrollee is enrolled, if applicable.

(b) In determining the appropriate length of time for a stay, the department or a managed care organization shall consider the health status and care needs of the individual.

(2)

(a) A recipient's continued eligibility for inpatient psychiatric hospital services shall be reevaluated at least once every thirty (30) days.

(b) Upon the expiration of a certified length of stay, the Medicaid Program shall not be responsible for the cost of care of a continuing stay unless the recipient or the recipient's authorized representative:

1. Requests a continuing stay; and
2.
a. The department approves the continued stay; or
b. For an enrollee, the managed care organization in which the enrollee is enrolled approves the continued stay.

Section 6. Other Limitations and Exclusions.

(1) An admission for diagnostic purposes shall only be covered if the diagnostic procedure cannot be performed on an outpatient basis.

(2) The Medicaid Program shall not reimburse for any day in which a recipient is not present in the psychiatric hospital.

(3) The Medicaid Program shall not reimburse for a court-ordered psychiatric hospital admission unless the department determines that the admission meets the criteria established in Section 3(1) of this administrative regulation.

(4) The Medicaid Program shall not reimburse for:

(a) An elective admission; or

(b) An admission for substance use treatment.

Section 7. Records Maintenance.

(1)

(a) For each recipient, a psychiatric hospital shall maintain a health record that shall:

1. Be:
   a. Current;
   b. Readily retrievable;
   c. Organized;
   d. Complete; and
   e. Legible;
2. Meet the record requirements established in
   a. 902 KAR 20:180;
   b. KRS 194A.060;
   c. KRS 434.840 through 434.860;
   d. KRS 422.317; and
   e. 42 C.F.R. 431 Subpart F;
3. Document the need for admission and appropriate utilization of services;
4. Be made available for inspection or copying or provided to the following upon request:
   a. A representative of the United States Department of Health and Human Services or its designee;
   b. The United States Office of the Attorney General or its designee;
   c. The Commonwealth of Kentucky, Office of the Attorney General or its designee;
   d. The Commonwealth of Kentucky, Office of the Auditor of Public Accounts or its designee;
   e. The Commonwealth of Kentucky, Cabinet for Health and Family Services, Office of the Inspector General or its designee;
   f. The department; or
   g. Personnel of the managed care organization in which the recipient is enrolled if applicable; and
5. Contain a:
   a. Physician's certification statement documenting the medical necessity of the recipient's:
      (i) Admission to the psychiatric hospital; and
      (ii) If applicable, continued stay in the psychiatric hospital;
   b. Copy of the recipient's most recent plan of care that:
      (i) Has been established and approved by the recipient's physician; and
      (ii) Shall include the date of the most recent interdisciplinary team review or revision of the plan of care;
   c. Copy of the Medicare remittance advice of explanation of Medicare benefits if the recipient has Medicare coverage for inpatient psychiatric services; and
   d. Copy of any Medicare denial letters if applicable.

(b) A physician's certification statement shall:

1. Be made no earlier than sixty (60) days prior to the recipient's admission to the psychiatric hospital; or
2. Not be made prior to the individual applying for Medicaid benefits while in an institutional setting.

(c) A licensed staff or consulting physician shall sign and date a certification statement.

(d) Failure to provide information in accordance with paragraph (a) of this subsection shall result in denial of payment for any service associated with the requested information.

(2) For each recipient, a psychiatric hospital shall have a physician's certification statement documenting the necessity of the psychiatric hospital admission.

(3) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the psychiatric 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:

(a)

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

(b)

1. 42 U.S.C. 290ee-3; and
2. 42 C.F.R. Part 2.

(4)

(a) Except as established in paragraph (b) or (c) of this subsection, a psychiatric hospital shall maintain a case 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 psychiatric hospital 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.

(5)

(a) A psychiatric hospital shall comply with 45 C.F.R. Part 164.

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

1. Be treated as confidential; and
2. Not be disclosed to an unauthorized individual.

Section 8. 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) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The Medicaid Program's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals.

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

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

(907 KAR 010:016. 2 Ky.R. 103; eff. 9-10-1975; Recodified from 904 KAR 1:016, 5-2-1986; 14 Ky.R. 525; eff. 10-2-1987; 17 Ky.R. 559; eff. 9-19-1990; 19 Ky.R. 2338; 20 Ky.R. 87; eff. 6-16-1993; 21 Ky.R. 2837; eff. 6-21-1995; Recodified from 907 KAR 1:016, eff. 5-3-2011; 41 Ky.R. 2442; 42 Ky.R. 420; 753; eff. 10-2-2015; Cert. eff. 8-10-2022; 52 Ky.R.

649; eff. 1-22-2026.)COMPILER'S NOTE: 2025 RS HB 6, enacted by the General Assembly on March 27, 2025, altered the information to be provided at the time an administrative regulation is filed. Aside from formatting changes necessary to upload the regulation into the LRC's publication application, this regulation has been published as submitted by the agency.

LISA D. LEE, Commissioner
STEVEN J. STACK, MD, MBA, Secretary

APPROVED BY AGENCY: August 1, 2025
FILED WITH LRC: September 9, 2025 at 10:09 a.m.
PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on November 24, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by November 17, 2025, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation through November 30, 2025. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.
CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.