907 KAR 15:050. Coverage provisions and requirements regarding targeted case management for individuals with a mental health or substance use disorder and chronic or complex physical health issues.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396n(g).

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program targeted case management services for individuals with a co-occurring mental health or substance use disorder and chronic or complex physical health issues.

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

(1) Medically necessary; and

(2) Provided:

(a) To a recipient; and

(b) By a provider that meets the provider participation requirements established in Section 3 of this administrative regulation.

Section 2. Eligibility Criteria.

(1) To be eligible for targeted case management services under this administrative regulation, a recipient shall:

(a)

1. Have a:

a. Primary moderate or severe substance use disorder diagnosis; or

b. Severe mental illness;

2. Have a chronic or complex physical health issue;

3. Not be:

a. Over the age of twenty-one (21) years and under the age of sixty-four (64) years while receiving services in an institution for mental diseases; or

b. An inmate of a public institution; and

4.

a. Need assistance with access to:

(i) Housing; or

(ii) Vocational, medical, social, educational, or other community services or supports;

b. Have been involved with at least one (1) child welfare agency or criminal justice agency; or

c. Be:

(i) In the custody of the Department for Community Based Services;

(ii) At risk of an out-of-home placement; or

(iii) At risk of inpatient mental health treatment; or

(b)

1. Be a child with a severe emotional disability as defined in KRS 200.503(3);

2. Have a chronic or complex physical health issue; and

3.

a. Need assistance with access to:

(i) Housing; or

(ii) Vocational, medical, social, educational, or other community services or supports;

b. Have been involved with at least one (1) child welfare agency or criminal justice agency; or

c. Be:

(i) In the custody of the Department for Community Based Services;

(ii) At risk of an out-of-home placement; or

(iii) At risk of inpatient mental health treatment.

(2)

(a) A severe mental illness shall be a diagnosis of a major mental disorder as included in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders™ under:

1. Schizophrenia spectrum and other psychiatric disorders;
2. Bipolar and related disorders;
3. Depressive disorders; or
4. Post-traumatic stress disorders (under trauma and stressor related disorders).

(b) A recipient's information and history, for the purpose of determining if the recipient has a severe mental illness, shall indicate that the recipient exhibits persistent disability and significant impairment in major areas of community living.

(c) In addition to the requirements established in paragraphs (a) and (b) of this subsection, to qualify as having a severe mental illness, a recipient shall:

1. Have clinically significant symptoms which have persisted for a continuous period of at least two (2) years; or

2.

a. Have been hospitalized for mental illness more than once within the past two (2) years; and

b. Be significantly impaired in the ability to function socially or occupationally or both.

(3) A moderate or severe substance use disorder shall be a moderate or severe substance use disorder as defined in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders™.

(4)

(a) A chronic or complex physical health issue shall include:

1. A cardiovascular disorder;
2. A respiratory disorder;
3. A genito urinary disorder;
4. An endocrine disorder;
5. A musculoskeletal disorder;
6. A neurological disorder;
7. An immune system disorder;
8. Obesity;
9. Cancer;
10. Deafness; or
11. Blindness.

(b) In addition to meeting the requirement established in paragraph (a) of this subsection, to qualify as having a chronic or complex physical health issue, a recipient shall:

1. Have clinically significant symptoms which have persisted for a continuous period of at least two (2) years; or

2.

a. Have been hospitalized as a result of the individual's physical health issue more than once within the past two (2) years; and

b. Be currently impaired in the ability to function socially or occupationally or both.

(c) Documentation of a recipient's chronic or complex physical health diagnosis that is signed and dated by a qualified medical professional shall be present in the recipient's medical record.

Section 3. Provider Requirements.

(1)

(a) To be eligible to provide services under this administrative regulation, an individual, entity, or organization shall:

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

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

3. Be:

a. A community mental health center;

b. An individual or provider group authorized to provide behavioral health services pursuant to 907 KAR 15:010;

c. A behavioral health services organization;

d. A Level I psychiatric residential treatment facility only if the recipient is under twenty-one (21) years of age;

e. A Level II psychiatric residential treatment facility only if the recipient is under twenty-one (21)years of age;

f. A chemical dependency treatment center only if the recipient has a substance use disorder;

g. An outpatient hospital; or

h. A psychiatric hospital; and

4. Have:

a. For each service it provides, the capacity to provide the full range of the service as established in this administrative regulation;

b. Documented experience in serving the population of individuals with behavioral health disorders relevant to the particular services provided;

c. The administrative capacity to ensure quality of services;

d. A financial management system that provides documentation of services and costs;

e. The capacity to document and maintain individual case records;

f. Documented programmatic and administrative experience in providing comprehensive case management services; and

g. Documented referral systems and linkages and referral ability with essential social and health services agencies.

(b) The documentation referenced in paragraph (a)4.b., f., and g. of this subsection shall be subject to audit by:

1. The department;

2. The Department for Behavioral Health, Developmental and Intellectual Disabilities;

3. The Cabinet for Health and Family Services, Office of Inspector General;

4. A managed care organization, if a targeted case manager provider is enrolled in its network;

5. The Centers for Medicare and Medicaid Services;

6. The Kentucky Office of the Auditor of Public Accounts; or

7. The United States Department of Health and Human Services, Office of the Inspector General.

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

(3) A targeted case management services provider shall:

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

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

Section 4. Case Manager Requirements.

(1) A case manager shall:

(a)

1. Have at least a bachelor of arts or science degree in a behavioral science including:

a. Psychology;
b. Sociology;
c. Social work;
d. Family studies;
e. Human services;
f. Counseling;
g. Nursing;
h. Behavioral analysis;
i. Public health;
j. Special education;
k. Gerontology;
l. Recreational therapy;
m. Education;
n. Occupational therapy;
o. Physical therapy;
p. Speech-language pathology;
q. Rehabilitation counseling; or
r. Faith-based education;

2. Be a certified alcohol and drug counselor who has a bachelor of arts or science degree; or

3. As authorized pursuant to subsection (5) of this section, have:

a. Provided targeted case management services to a recipient any time from April 1, 2014 to the effective date of this administrative regulation; or

b. Supervised the provision of targeted case management services to a recipient any time from April 1, 2014 to the effective date of this administrative regulation;

(b) Have successfully completed case management training pursuant to 908 KAR 2:260; and

(c) Successfully complete continuing education requirements pursuant to 908 KAR 2:260.

(2)

(a) Supervision by a behavioral health professional who has completed case management training approved by DBHDID shall occur at least twice per month.

(b) At least one (1) of these supervisory contacts shall be on an individual basis and face-to-face.

(3)

(a) Except as established in paragraph (b) of this subsection, a case manager shall have at least one (1) year of full-time employment working directly with individuals in a human service setting after completing the requirements established in subsection (1)(a) of this section.

(b) A master's degree in one (1) or more of the following behavioral science disciplines may be substituted for the one (1) year of experience:

1. Psychology;
2. Sociology;
3. Social work;
4. Family studies;
5. Human services;
6. Counseling;
7. Nursing;
8. Behavioral analysis;
9. Public health;
10. Special education;
11. Gerontology;
12. Recreational therapy;
13. Education;
14. Occupational therapy;
15. Physical therapy;
16. Speech-language pathology;
17. Rehabilitation counseling; or
18. Faith-based education.

(4) A behavioral health professional shall be:

(a) An advanced practice registered nurse;

(b) A licensed clinical social worker;

(c) A licensed marriage and family therapist;

(d) A licensed professional clinical counselor;

(e) A licensed psychological practitioner;

(f) A licensed psychologist;

(g) A licensed professional art therapist;

(h) A physician;

(i) A psychiatrist;

(j) A behavioral health practitioner under supervision except that a certified alcohol and drug counselor shall not be considered a behavioral health professional for the purpose of providing targeted case management to an individual unless the individual has a substance use disorder;

(k) A registered nurse working under the supervision of a physician or advanced practice registered nurse; or

(l) An individual with a bachelor's degree stated in subsection (1)(a)1. of this section who:

1. Is working under the supervision of a billing supervisor; and
2. Has at least five (5) years of documented full-time experience providing specialized case management services for the target population.

(5)

(a) In order to be approved, a request for the targeted case manager qualification exemption established in subsection (1)(a)3. of this section shall be:

1. Submitted in writing to the department, or for an enrollee, to the managed care organization in which the enrollee is enrolled, with documentation of the individual's experience in:

a. Providing targeted case management services to a recipient; or

b. Supervising the provision of targeted case management services to a recipient; and

2. Received by the department or managed care organization no later than June 30, 2015.

(b) The department or managed care organization shall not grant any exemption pursuant to subsection (1)(a)3. of this section that it receives after June 30, 2015.

Section 5. Freedom of Choice of Provider.

(1) A recipient shall have the freedom to choose from which:

(a) Case manager to receive services within the recipient's geographic area identified in the recipient's care plan; and

(b) Provider of non-targeted case management Medicaid covered services to receive services.

(2) A case manager shall not have the authority to authorize or deny the provision of non-targeted case management Medicaid covered services to a recipient.

(3) A recipient shall not be required to receive targeted case management services as a condition of receiving non-targeted case management Medicaid-covered services.

Section 6. Covered Services.

(1) Targeted case management services covered under this administrative regulation shall:

(a) Be services furnished to assist a recipient in gaining access to needed medical, social, educational, or other services; and

(b) Include:

1. A comprehensive assessment and periodic reassessments of the recipient's needs to determine the need for any medical, educational, social, or other services;

2. The development and periodic revision of a specific care plan for the recipient;

3. A referral or related activities to help the recipient obtain needed services;

4. Monitoring or follow-up activities; or

5. Contacts with non-recipients who are directly related to help with identifying the recipient's needs and care for the purpose of:

a. Helping the recipient access services;

b. Identifying supports necessary to enable the recipient to obtain services;

c. Providing a case manager with useful input regarding the recipient's past or current functioning, symptoms, adherence to treatment, or other information relevant to the recipient's behavioral health condition; or

d. Alerting a case manager to a change in the recipient's needs.

(2)

(a) An assessment or reassessment shall include:

1. Taking the recipient's history;

2. Identifying the recipient's strengths and needs and completing related documentation; and

3. Gathering information from other sources including family members, medical providers, social workers, or educators, to form a complete assessment of the recipient.

(b) A face-to-face assessment or reassessment shall be completed:

1. At least annually; or

2. More often if needed based on changes in the recipient's condition.

(3) The development and periodic revision of the recipient's care plan shall:

(a) Specify the goals and actions to address the medical, social, educational, or other services needed by the recipient;

(b) Include ensuring the active participation of the recipient and working with the recipient, the recipient's authorized health care decision maker, or others to develop the

goals; and

(c) Identify a course of action to respond to the assessed needs of the recipient.

(4) A referral or related activities shall include activities that help link the recipient with medical providers, social providers, educational providers, or other programs and services that are capable of providing needed services to:

(a) Address the identified needs; and

(b) Achieve goals specified in the care plan.

(5)

(a) Monitoring and follow-up activities shall:

1. Be activities and contacts that:

a. Are necessary to ensure that the recipient's care plan is implemented;

b. Adequately address the recipient's strengths and needs; and

c. May be with the recipient, the recipient's family members, the recipient's service providers, or other entities or individuals;

2. Be conducted as frequently as necessary; and

3. Include making necessary adjustments in the recipient's care plan and service arrangements with providers.

(b) Monitoring shall:

1. Occur at least once every three (3) months;

2. Be face-to-face; and

3. Determine if:

a. The services are being furnished in accordance with the recipient's care plan;

b. The services in the recipient's care plan are adequate to meet the recipient's needs; and

c. Changes in the needs or status of the recipient are reflected in the care plan.

Section 7. No Duplication of Service.

(1) The department shall not pay for targeted case management services which duplicate services provided by another public agency or a private entity.

(2)

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

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

Section 8. Exclusions and Limits.

(1) Targeted case management services shall not include services defined in 42 C.F.R. 440.169 if the activities:

(a) Are an integral and inseparable component of another covered Medicaid service; or

(b) Constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible recipient has been referred, including:

1. Foster care programs;

2. Research gathering and completing documentation required by the foster care program;

3. Assessing adoption placements;

4. Recruiting or interviewing potential foster care parents;

5. Serving legal papers;

6. Home investigations;

7. Providing transportation;

8. Administering foster care subsidies; or

9. Making placement arrangements.

(2) A recipient who is receiving case management services under a 1915(c) home and community based waiver program shall not be eligible to receive targeted case management services under this administrative regulation.

(3) An individual who provides targeted case management to a recipient shall not provide any other Medicaid covered service to the recipient.

(4)

(a) Beginning October 1, 2015, except as established in paragraph (c) of this subsection, if an individual provides targeted case management services to a recipient, the maximum number of recipients to whom the individual may provide services at any point in time, whether targeted case management services or other services, shall be twenty-five (25).

(b) As an example of the limit established in paragraph (a) of this subsection, if an individual provides targeted case management services to ten (10) recipients, the individual may provide individual outpatient therapy to no more than fifteen (15) other recipients at the same time.

(c) The limit established in paragraph (a) of this subsection shall not apply to:

1. Mobile crisis services;
2. Crisis intervention services; or
3. Screenings.

Section 9. Records Maintenance, Documentation, Protection, and Security.

(1) A targeted case management services provider shall maintain a current case record for each recipient.

(2)

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

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

(3) A case record shall:

(a) Include:

1. The recipient's name;
2. The time and date corresponding to each occasion in which a service was provided to the recipient;
3. The name of the targeted case management services:
   a. Provider agency, if an agency; and
   b. Practitioner who provided the targeted case management services;
4. The nature, content, and contacts that occurred regarding the targeted case management services provided;
5. Whether goals in the recipient's care plan have been achieved;
6. Whether the recipient has declined to receive any services in the recipient's care plan;
7. A timeline for obtaining needed services; and
8. A timeline for reevaluating the recipient's care plan; and

(b) Be:

1. Maintained in an organized and secure 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 if applicable;
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.

(4)

(a) A discharge summary shall:

1. Be required, at the time a decision is made that services are terminated, 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 recipient toward reaching goals and objectives established in the recipient's care plan; and

b. Recipient's condition upon termination and disposition.

(b) A case record relating to a recipient who was terminated from receiving services shall be fully completed within ten (10) business days following termination.

(5) If a recipient's case is reopened within ninety (90) calendar 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.

(6) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring targeted case management services provider 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) The Health Insurance Portability and Accountability Act codified as 45 C.F.R. Parts 160,162, and 164;

(b) 42 U.S.C. 1320d-2 to 1320d-8; and

(c) 42 C.F.R. Part 2.

(7)

(a) If a targeted case management services provider'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 case records of the targeted case management services provider shall:

1. Remain the property of the targeted case management services provider; and

2. Be subject to the retention requirements established in subsection (8) of this section.

(b) A targeted case management services provider shall have a written plan addressing how to maintain case records in the event of an owner's death or owners' deaths.

(8)

(a) Except as established in paragraph (b) or (c) of this subsection, a targeted case management services provider 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 provider shall maintain the recipient's record for the longer 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.

(9)

(a) A targeted case management services provider shall comply with 45 C.F.R. Part 164.

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

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

(c)

1. Upon request, a targeted case management services provider 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.
2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 10. Medicaid Program Participation Compliance.

(1) A targeted case management services 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 targeted case management services provider receives any duplicate payment or overpayment from the department, regardless of reason, the targeted case management services provider shall return the payment to the department.

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

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

(3)

(a) When the department makes payment for a covered service and the targeted case management services provider 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 provider.

(b)

1. A targeted case management services provider 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. Targeted case management services provider makes the recipient aware in advance of providing the service that the:
      (i) Recipient is liable for the payment; and

(ii) Department is not covering the service.

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

a. Targeted case management services provider shall not bill the department for the service; and

b. Department shall not:

(i) Be liable for any part of the payment associated with the service; and

(ii) Make any payment to the targeted case management services provider regarding the service.

(4)

(a) A targeted case management services provider attests by the targeted case management services provider 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 a targeted case management services provider receives a request from the:

a. Department to provide a claim, related information, related documentation, or record for auditing purposes, the targeted case management services provider 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 targeted case management services provider 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 a targeted case management services provider to provide requested information shall be:

(i) A reasonable amount of time given the nature of the request and the circumstances surrounding the request; and

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

b. A targeted case management services provider may request a longer timeframe to provide information to the department or a managed care organization if the targeted case management services provider 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 a targeted case management services provider shall result in the suspension or termination of the targeted case management services provider from Medicaid Program participation.

Section 11. Third Party Liability.

(1) A targeted case management services provider shall comply with KRS 205.622.

(2) If a third party is liable to pay for targeted case management services, the department shall not pay for the services.

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 targeted case management services 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 targeted case management services 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 targeted case management services 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) Medical record; or

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

Section 14. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

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

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

Section 15. 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.

(41 Ky.R. 1271; Am. 1821; 1984; eff. 4-3-2015; Cert. eff. 3-28-2022.)