



1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amended After Comments)

5 907 KAR 15:080. Coverage provisions and requirements regarding [~~outpatient~~] chemical
6 dependency treatment center services.

7 RELATES TO: KRS 205.520, 205.622, 309.0831, 21 U.S.C. 823(g)(2), 42 U.S.C.
8 1396a(a)(10)(B), 1396a(a)(23), 42 C.F.R. 435.1010

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

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services, has a responsibility to administer the Medicaid
12 Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any
13 requirement that may be imposed or opportunity presented by federal law to qualify for federal
14 Medicaid funds. This administrative regulation establishes the coverage provisions and
15 requirements regarding Medicaid Program outpatient and inpatient chemical dependency
16 treatment center services.

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

19 (a) Medically necessary; and

20 (b) Provided:

21 1. To a recipient; and

1 2. By a chemical dependency treatment center that meets the provider participation
2 requirements established in Section 2 of this administrative regulation.

3 (2)(a) Direct~~[Face to face]~~ contact between a practitioner and a recipient shall be required for
4 each service except for:

5 1. Collateral outpatient therapy for a recipient under the age of twenty-one (21) years if the
6 collateral outpatient therapy is in the recipient's plan of care;

7 2. A family outpatient therapy service in which the corresponding current procedural
8 terminology code establishes that the recipient is not present; or

9 3. A psychological testing service comprised of interpreting or explaining results of an
10 examination or data to family members or others in which the corresponding current procedural
11 terminology code establishes that the recipient is not present.

12 (b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be
13 covered.

14 (3) A billable unit of service shall be actual time spent delivering a service in an~~[a face to face]~~
15 encounter.

16 (4) A service shall be:

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

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

19 (5)(a) A chemical dependency treatment center shall establish a plan of care for each recipient
20 receiving services from a chemical dependency treatment center.

21 (b) A plan of care shall meet the treatment plan requirements established in 902 KAR 20:160.

22 Section 2. Provider Participation. (1)(a) To be eligible to provide services under this
23 administrative regulation, a chemical dependency treatment center shall:

1 1. Be currently enrolled as a provider in the Kentucky Medicaid Program in accordance with
2 907 KAR 1:672;

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

5 3. Be licensed as a chemical dependency treatment center to provide outpatient and inpatient
6 behavioral health services in accordance with 902 KAR 20:160; and

7 4. Have:

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

10 b. Documented experience in serving individuals with mental health, substance use, or co-
11 occurring~~behavioral health~~ disorders;

12 c. The administrative capacity to ensure quality of services;

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

14 e. The capacity to document and maintain individual health records.

15 (b) The documentation referenced in paragraph (a)4.b. of this subsection shall be subject to
16 audit by:

17 1. The department or its designee;

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

19 3. A managed care organization, if the chemical dependency treatment center is enrolled in its
20 network;

21 4. The Centers for Medicare and Medicaid Services;

22 5. The Kentucky Office of the Auditor of Public Accounts; or

23 6. The United States Department of Health and Human Services, Office of the Inspector

1 General.

2 (2) In accordance with 907 KAR 17:015, Section 3(3), a chemical dependency treatment center
3 that[which] provides a service to an enrollee shall not be required to be currently participating in
4 the fee-for-service Medicaid Program.

5 (3) A chemical dependency treatment center shall:

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

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

10 (4)(a) Except as provided by paragraph (b) of this subsection, a chemical dependency treatment
11 center shall possess accreditation, within one (1) year of initial enrollment, by one (1) of the
12 following:

13 1. The Joint Commission;

14 2. The Commission on Accreditation of Rehabilitation Facilities;

15 3. The Council on Accreditation; or

16 4. A nationally recognized accreditation organization.

17 (b) The department shall grant a one (1) time extension to a chemical dependency treatment
18 center that requests a one (1) time extension to complete the accreditation process, if the request
19 is submitted at least ninety (90) days prior to expiration of provider enrollment.

20 Section 3. Covered Services.

21 (1) Reimbursement shall not be available for services performed within a chemical dependency
22 treatment program by a:

23 (a) Licensed behavior analyst;

1 (b) Licensed assistant behavior analyst;

2 (c) Registered behavior technician; or

3 (d) Community support associate.

4 (2) The services covered may be provided for a substance use disorder or co-occurring
5 disorders.

6 (3)[(2)] The [following] services listed in this subsection shall be covered under this
7 administrative regulation in accordance with the requirements established in this subsection.[:

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

9 ~~—1. A licensed psychologist;~~

10 ~~—2. A licensed psychological practitioner;~~

11 ~~—3. A certified psychologist with autonomous functioning;~~

12 ~~—4. A licensed clinical social worker;~~

13 ~~—5. A licensed professional clinical counselor;~~

14 ~~—6. A licensed professional art therapist;~~

15 ~~—7. A licensed marriage and family therapist;~~

16 ~~—8. A physician;~~

17 ~~—9. A psychiatrist;~~

18 ~~—10. An advanced practice registered nurse;~~

19 ~~—11. A licensed psychological associate working under the supervision of a board approved~~
20 ~~licensed psychologist;~~

21 ~~—12. A certified psychologist working under the supervision of a board approved licensed~~
22 ~~psychologist;~~

23 ~~—13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~

1 ~~administrative regulation; or~~

2 ~~—14. A behavioral health practitioner under supervision, except for a licensed assistant behavior~~

3 ~~analyst;~~

4 ~~—(b) An assessment provided by:~~

5 ~~—1. A licensed psychologist;~~

6 ~~—2. A licensed psychological practitioner;~~

7 ~~—3. A certified psychologist with autonomous functioning;~~

8 ~~—4. A licensed clinical social worker;~~

9 ~~—5. A licensed professional clinical counselor;~~

10 ~~—6. A licensed professional art therapist;~~

11 ~~—7. A licensed marriage and family therapist;~~

12 ~~—8. A physician;~~

13 ~~—9. A psychiatrist;~~

14 ~~—10. An advanced practice registered nurse;~~

15 ~~—11. A licensed behavior analyst;~~

16 ~~—12. A licensed psychological associate working under the supervision of a board approved~~
17 ~~licensed psychologist;~~

18 ~~—13. A certified psychologist working under the supervision of a board approved licensed~~
19 ~~psychologist;~~

20 ~~—14. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~
21 ~~administrative regulation; or~~

22 ~~—15. A behavioral health practitioner under supervision;~~

23 ~~—(c) Psychological testing provided by:~~

- 1 —~~1. A licensed psychologist;~~
- 2 —~~2. A licensed psychological practitioner;~~
- 3 —~~3. A certified psychologist with autonomous functioning;~~
- 4 —~~4. A licensed psychological associate working under the supervision of a board approved~~
- 5 ~~licensed psychologist; or~~
- 6 —~~5. A certified psychologist working under the supervision of a board approved licensed~~
- 7 ~~psychologist;~~
- 8 —(d) ~~Day treatment or mobile crisis services provided by:~~
- 9 —~~1. A licensed psychologist;~~
- 10 —~~2. A licensed psychological practitioner;~~
- 11 —~~3. A certified psychologist with autonomous functioning;~~
- 12 —~~4. A licensed clinical social worker;~~
- 13 —~~5. A licensed professional clinical counselor;~~
- 14 —~~6. A licensed professional art therapist;~~
- 15 —~~7. A licensed marriage and family therapist;~~
- 16 —~~8. A physician;~~
- 17 —~~9. A psychiatrist;~~
- 18 —~~10. An advanced practice registered nurse;~~
- 19 —~~11. A licensed psychological associate working under the supervision of a board approved~~
- 20 ~~licensed psychologist;~~
- 21 —~~12. A certified psychologist working under the supervision of a board approved licensed~~
- 22 ~~psychologist;~~
- 23 —~~13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~

1 ~~administrative regulation;~~

2 ~~—14. A behavioral health practitioner under supervision, except for a licensed assistant behavior~~

3 ~~analyst; or~~

4 ~~—15. A peer support specialist working under the supervision of an approved behavioral health~~

5 ~~services provider;~~

6 ~~—(e) Peer support provided by a peer support specialist working under the supervision of an~~

7 ~~approved behavioral health services provider;~~

8 ~~—(f) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy~~

9 ~~provided by:~~

10 ~~—1. A licensed psychologist;~~

11 ~~—2. A licensed psychological practitioner;~~

12 ~~—3. A certified psychologist with autonomous functioning;~~

13 ~~—4. A licensed clinical social worker;~~

14 ~~—5. A licensed professional clinical counselor;~~

15 ~~—6. A licensed professional art therapist;~~

16 ~~—7. A licensed marriage and family therapist;~~

17 ~~—8. A physician;~~

18 ~~—9. A psychiatrist;~~

19 ~~—10. An advanced practice registered nurse;~~

20 ~~—11. A licensed behavior analyst;~~

21 ~~—12. A licensed psychological associate working under the supervision of a board approved~~

22 ~~licensed psychologist;~~

23 ~~—13. A certified psychologist working under the supervision of a board approved licensed~~

1 psychologist;

2 ~~—14. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~

3 ~~administrative regulation; or~~

4 ~~—15. A behavioral health practitioner under supervision;~~

5 ~~—(g) Family outpatient therapy provided by:~~

6 ~~—1. A licensed psychologist;~~

7 ~~—2. A licensed psychological practitioner;~~

8 ~~—3. A certified psychologist with autonomous functioning;~~

9 ~~—4. A licensed clinical social worker;~~

10 ~~—5. A licensed professional clinical counselor;~~

11 ~~—6. A licensed professional art therapist;~~

12 ~~—7. A licensed marriage and family therapist;~~

13 ~~—8. A physician;~~

14 ~~—9. A psychiatrist;~~

15 ~~—10. An advanced practice registered nurse;~~

16 ~~—11. A licensed psychological associate working under the supervision of a board approved~~

17 ~~licensed psychologist;~~

18 ~~—12. A certified psychologist working under the supervision of a board approved licensed~~

19 ~~psychologist;~~

20 ~~—13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~

21 ~~administrative regulation; or~~

22 ~~—14. A behavioral health practitioner under supervision, except for a licensed assistant behavior~~

23 ~~analyst; or~~

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

3 ~~—1. A licensed psychologist;~~

4 ~~—2. A licensed psychological practitioner;~~

5 ~~—3. A certified psychologist with autonomous functioning;~~

6 ~~—4. A licensed clinical social worker;~~

7 ~~—5. A licensed professional clinical counselor;~~

8 ~~—6. A licensed professional art therapist;~~

9 ~~—7. A licensed marriage and family therapist;~~

10 ~~—8. A physician;~~

11 ~~—9. A psychiatrist;~~

12 ~~—10. An advanced practice registered nurse;~~

13 ~~—11. A licensed psychological associate working under the supervision of a board approved~~
14 ~~licensed psychologist;~~

15 ~~—12. A certified psychologist working under the supervision of a board approved licensed~~
16 ~~psychologist;~~

17 ~~—13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this~~
18 ~~administrative regulation; or~~

19 ~~—14. A behavioral health practitioner under supervision, except for a licensed assistant behavior~~
20 ~~analyst.~~

21 ~~(3)](a) A screening shall:~~

22 ~~1. Determine the likelihood that an individual has a substance use disorder;~~

23 ~~2. Not establish the presence or specific type of disorder; [and]~~

- 1 3. Establish the need for an in-depth assessment;
- 2 4. Be provided face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and
- 3 5. Be provided by:
 - 4 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or
 - 5 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
 - 6 of this section.
- 7 (b) An assessment shall:
 - 8 1. Include gathering information and engaging in a process with the individual that enables the
 - 9 practitioner to:
 - 10 a. Establish the presence or absence of a substance use disorder;
 - 11 b. Determine the individual's readiness for change;
 - 12 c. Identify the individual's strengths or problem areas that may affect the treatment and recovery
 - 13 processes; and
 - 14 d. Engage the individual in ~~developing~~the development of an appropriate treatment
 - 15 relationship;
 - 16 2. Establish or rule out the existence of a clinical disorder or service need;
 - 17 3. Include working with the individual to develop a plan of care; ~~and~~
 - 18 4. Not include psychological or psychiatric evaluations or assessments;
 - 19 5. Utilize a multidimensional assessment that complies with the most current **version**~~edition~~
 - 20 of The ASAM Criteria to determine the most appropriate level of care;
 - 21 6. Be provided face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and
 - 22 7. Be provided by:
 - 23 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

1 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
2 of this section.

3 (c) Psychological testing shall:

4 1. Include[~~:~~

5 —~~a.] a psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual~~
6 ~~disabilities;~~

7 2. Include an[~~and b.] interpretation and a written report of testing results;~~

8 3. Be face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and

9 4. Be provided by:

10 a. A licensed psychologist;

11 b. A certified psychologist with autonomous functioning;

12 c. A licensed psychological practitioner;

13 d. A certified psychologist under supervision; or

14 e. A licensed psychological associate under supervision[~~and~~

15 —~~2. Be performed by an individual who has met the requirements of KRS Chapter 319 related to~~
16 ~~the necessary credentials to perform psychological testing].~~

17 (d) Crisis intervention:

18 1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating
19 the risk of physical or emotional harm to:

20 a. The recipient; or

21 b. Another individual;

22 2. Shall consist of clinical intervention and support services necessary to provide integrated
23 crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;

1 3. Shall be provided:

2 a. ~~[On-site in the facility where the outpatient behavioral health services are provided;~~

3 ~~—b.]~~As an immediate relief to the presenting problem or threat; and

4 ~~b.[e-]~~ In a one (1) on one (1)~~[face-to-face, one-on-one]~~ encounter between the provider and the
5 recipient, which is delivered either face-to-face or via telehealth if appropriate pursuant to 907
6 KAR 3:170;

7 4. Shall be followed by a referral to non-crisis services if applicable; ~~[and]~~

8 5. May include:

9 a. Further service prevention planning including~~[that includes]~~:

10 (i) Lethal means reduction for suicide risk; or

11 (ii) Substance use disorder relapse prevention; or

12 b. Verbal de-escalation, risk assessment, or cognitive therapy; and

13 6. Shall be provided by:

14 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

15 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
16 of this section.

17 (e) Mobile crisis services shall:

18 1. Be available twenty-four (24) hours per day, seven (7) days per week, every day of the year;

19 2. Be provided for a duration of less than twenty-four (24) hours;

20 3. Not be an overnight service;

21 ~~4.[Ensure access to a board-certified or board-eligible psychiatrist twenty four (24) hours per~~
22 ~~day, seven (7) days per week, every day of the year;~~

23 ~~—3. Be provided for a duration of less than twenty-four (24) hours;~~

1 —4. ~~Not be an overnight service;~~

2 —5.] Be a face-to-face, or via telehealth as appropriate pursuant to the most current version

3 of The ASAM Criteria and 907 KAR 3:170, multi-disciplinary team-based intervention in a

4 home or community setting that ensures access to substance use disorder services and supports to:

5 a. Reduce symptoms or harm; or

6 b. Safely transition an individual in an acute crisis to the appropriate least restrictive level of

7 care;

8 5.[6.] Involve all services and supports necessary to provide:

9 a. Integrated crisis prevention;

10 b. Assessment and disposition;

11 c. Intervention;

12 d. Continuity of care recommendations; and

13 e. Follow-up services;

14 6. Include access to a board-certified or board-eligible psychiatrist twenty-four (24) hours a

15 day, seven (7) days a week, every day of the year; and

16 7. Be provided by:

17 a. An approved behavioral health practitioner, as limited by subsection (1) of this section;

18 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)

19 of this section; or

20 c. A peer support specialist who:

21 (i) Is under the supervision of an approved behavioral health practitioner, as limited by

22 subsection (1) of this section; and

23 (ii) Provides support services for a mobile crisis service[face-to-face in a home or community

1 ~~setting~~].

2 (f)1. Day treatment shall be a non-residential, intensive treatment program for an individual
3 under the age of twenty-one (21) years who has:

4 a. A substance use disorder; and

5 b. A high risk of out-of-home placement due to a behavioral health issue.

6 2. Day treatment shall:

7 a. Be face-to-face, or via telehealth as appropriate pursuant to the most current version of

8 The ASAM Criteria and 907 KAR 3:170;

9 b. Consist of an organized, behavioral health program of treatment and rehabilitative services;

10 c.~~[b.]~~ Include:

11 (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

12 (ii) Behavior management and social skills training;

13 (iii) Independent living skills that correlate to the age and developmental stage of the recipient;

14 or

15 (iv) Services designed to explore and link with community resources before discharge and to
16 assist the recipient and family with transition to community services after discharge; and

17 d.~~[e.]~~ Be provided:

18 (i) In collaboration with the education services of the local education authority including those
19 provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C.

20 701 et seq. (Section 504 of the Rehabilitation Act);

21 (ii) On school days and during ~~[on non-instructional weekdays during the school year~~
22 ~~including]~~ scheduled school breaks;

23 (iii) In coordination with the recipient's individualized educational plan or Section 504 plan if

1 the recipient has an individualized educational plan or Section 504 plan; and

2 (iv) [~~Under the supervision of a licensed or certified approved behavioral health services~~
3 ~~provider or a behavioral health practitioner working under clinical supervision; and~~

4 ~~—(v)] With a linkage agreement with the local education authority that specifies the~~

5 responsibilities of the local education authority and the day treatment provider.

6 3. To provide day treatment services, a chemical dependency treatment center shall have:

7 a. The capacity to employ staff authorized to provide day treatment services in accordance with

8 this section and to coordinate the provision of services among team members; and

9 b. Knowledge of substance use disorders and co-occurring disorders.

10 4. Day treatment shall not include a therapeutic clinical service that is included in a child's

11 individualized education program or Section 504 plan.

12 5. Day treatment shall be provided by:

13 a. An approved behavioral health practitioner, as limited by subsection (1) of this section;

14 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
15 of this section; or

16 c. A peer support specialist who:

17 (i) Is under the supervision of an approved behavioral health practitioner, as limited by
18 subsection (1) of this section; and

19 (ii) Provides support services for a day treatment service.

20 (g)1. Peer support services shall:

21 a. Be emotional support that is provided by:

22 (i) An individual who has been trained and certified in accordance with 908 KAR 2:220 [~~or 907~~
23 ~~KAR 2:240]~~and who is experiencing or has experienced a substance use disorder to a recipient by

1 sharing a similar substance use disorder in order to bring about a desired social or personal change;

2 (ii) A parent or other family member, who has been trained and certified in accordance with
3 908 KAR 2:230, of a child having or who has had a substance use disorder to a parent or family
4 member of a child sharing a similar substance use disorder in order to bring about a desired social
5 or personal change;[ø]

6 (iii) An individual who has been trained and certified in accordance with 908 KAR 2:240 and
7 identified as experiencing a substance use disorder [~~A family member who has been trained and~~
8 ~~certified in accordance with 908 KAR 2:230 of a child having or who has had a substance use~~
9 ~~disorder to a parent or family member of a child sharing a similar substance use disorder in order~~
10 ~~to bring about a desired social or personal change~~]; or

11 (iv) A registered alcohol and drug peer support specialist who has been trained and certified in
12 accordance with KRS 309.0831 and is a self-identified consumer of substance use disorder
13 services who provides emotional support to others with substance use disorder to achieve a desired
14 social or personal change;

15 b. Be an evidence-based practice;

16 c. Be structured and scheduled non-clinical therapeutic activities with an individual recipient or
17 a group of recipients;

18 d. Be provided face-to-face, or via telehealth as appropriate pursuant to the most current
19 version of The ASAM Criteria and 907 KAR 3:170;

20 e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of
21 community living skills for the recipient;

22 f. Except for the engagement into substance use disorder treatment through an emergency
23 department bridge clinic,[e-] be coordinated within the context of a comprehensive, individualized

1 plan of care developed through a person-centered planning process;

2 ~~g.[f.]~~ Be identified in each recipient's plan of care; and

3 ~~h.[g.]~~ Be designed to contribute directly to the recipient's individualized goals as specified in
4 the recipient's plan of care.

5 2. To provide peer support services, a chemical dependency treatment center shall:

6 a. Have demonstrated:

7 (i) The capacity to provide peer support services for the behavioral health population being
8 served including the age range of the population being served; and

9 (ii) Experience in serving individuals with behavioral health disorders;

10 b. Employ peer support specialists who are qualified to provide peer support services in
11 accordance with 908 KAR 2:220, 908 KAR 2:230,~~[or]~~ 908 KAR 2:240, or KRS 309.0831;

12 c. Use an approved behavioral health practitioner~~[services provider]~~ to supervise peer support
13 specialists;

14 d. Have the capacity to coordinate the provision of services among team members; ~~[and]~~

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

17 f. Require individuals providing peer support services to recipients to provide no more than
18 thirty (30) hours per week of direct recipient contact; and

19 g. Require peer support services provided to recipients in a group setting to not exceed eight
20 (8) individuals within any group at one (1) time.

21 (h)1. Intensive outpatient program services shall:

22 a. Be an alternative to or transition from a higher level of care for a substance use disorder or
23 co-occurring disorders~~[inpatient hospitalization or partial hospitalization for a substance use~~

1 ~~disorder~~];

2 b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is
3 significantly more intensive than individual outpatient therapy, group outpatient therapy, or family
4 outpatient therapy;

5 c. Meet the service criteria, including the components for support systems, staffing, and
6 therapies outlined in the most current ~~version~~**[~~edition~~]** of The ASAM Criteria for intensive
7 outpatient level of care services;

8 d. Be provided face-to-face, or via telehealth as appropriate pursuant to the most current
9 **version of The ASAM Criteria and 907 KAR 3:170;**

10 e. Be provided at least three (3) hours per day at least three (3) days per week for adults;

11 f. Be provided at least six (6) hours per week for adolescents; and

12 g.~~[d.]~~ Include:

13 (i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless
14 contraindicated;

15 (ii) Crisis intervention; or

16 (iii) Psycho-education related to identified goals in the recipient's treatment plan.

17 2. During psycho-education, the recipient or recipient's family member shall be:

18 a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and
19 the reasons why a particular treatment might be effective for reducing symptoms; and

20 b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

21 3. An intensive outpatient program services treatment plan shall:

22 a. Be individualized; and

23 b. Focus on stabilization and transition to a lesser level of care.

1 4. To provide intensive outpatient program services, a chemical dependency treatment center
2 shall have:

3 a. Access to a board-certified or board-eligible psychiatrist for consultation;

4 b. Access to a psychiatrist, physician, or advanced practice registered nurse for medication
5 prescribing and monitoring;

6 c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one
7 (1) staff person;

8 d. The capacity to provide services utilizing a recognized intervention protocol based on
9 nationally accepted treatment principles; and

10 e. The capacity to employ staff authorized to provide intensive outpatient program services in
11 accordance with this section and to coordinate the provision of services among team members.

12 5. Intensive outpatient program services shall be provided by:

13 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

14 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
15 of this section.

16 (i) Individual outpatient therapy shall:

17 1. Be provided to promote the:

18 a. Health and wellbeing of the recipient; and

19 b. Restoration of a recipient to their best possible functional level from substance use disorder
20 or co-occurring disorders[Recipient's recovery from a substance use disorder];

21 2. Consist of:

22 a. A face-to-face encounter or via telehealth as appropriate pursuant to 907 KAR 3:170 that is
23 a one (1) on one (1) encounter between the provider and recipient[, one on one encounter between

1 ~~the provider and recipient~~]; and

2 b. A behavioral health therapeutic intervention provided in accordance with the recipient's
3 identified plan of care;

4 3. Be aimed at:

5 a. Reducing adverse symptoms;

6 b. Reducing or eliminating the presenting problem of the recipient; and

7 c. Improving functioning; ~~and~~

8 4. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy
9 per recipient unless additional time is medically necessary; and

10 5. Be provided by:

11 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

12 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
13 of this section.

14 (j)1. Group outpatient therapy shall:

15 a. Be a behavioral health therapeutic intervention provided in accordance with a recipient's
16 identified plan of care;

17 b. Be provided to promote the:

18 (i) Health and wellbeing of the individual~~[recipient]~~; and

19 (ii) Restoration of a recipient to their best possible functional level from a substance use
20 disorder or co-occurring disorders~~[Recipient's recovery from a substance use disorder]~~;

21 c. Consist of a face-to-face, **or via telehealth as appropriate pursuant to the most current**
22 **version of The ASAM Criteria and 907 KAR 3:170,** behavioral health therapeutic intervention
23 provided in accordance with the recipient's identified plan of care;

- 1 d. Be provided to a recipient in a group setting:
 - 2 (i) Of nonrelated individuals except for multi-family group therapy; and
 - 3 (ii) Not to exceed twelve (12) individuals in size;
- 4 e. Focus on the psychological needs of the recipients as evidenced in each recipient's plan of
- 5 care;
- 6 f. Center on goals, including building and maintaining healthy relationships, personal goals
- 7 setting, and the exercise of personal judgment;
- 8 g. Not include physical exercise, a recreational activity, an educational activity, or a social
- 9 activity; and
- 10 h. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy
- 11 per recipient unless additional time is medically necessary.

12 2. The group shall have a:

- 13 a. Deliberate focus; and
- 14 b. Defined course of treatment.

15 3. The subject of group outpatient therapy shall relate to each recipient participating in the

16 group.

17 4. The provider shall keep individual notes regarding each recipient within[øf] the group and

18 within each recipient's health record.

19 5. Group outpatient therapy shall be provided by:

- 20 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or
- 21 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
- 22 of this section.

23 (k)1. Family outpatient therapy shall consist of a face-to-face or appropriate telehealth, pursuant

1 to 907 KAR 3:170, behavioral health therapeutic intervention provided:

2 a. Through scheduled therapeutic visits between the therapist and the recipient and at least one

3 (1) member of the recipient's family; and

4 b. To address issues interfering with the relational functioning of the family and to improve
5 interpersonal relationships within the recipient's home environment.

6 2. A family outpatient therapy session shall be billed as one (1) service regardless of the number
7 of individuals (including multiple members from one (1) family) who participate in the session.

8 3. Family outpatient therapy shall:

9 a. Be provided to promote the:

10 (i) Health and well-being of the individual~~[recipient]~~; or

11 (ii) Restoration of a recipient to their best possible functional level from a substance use
12 disorder or co-occurring disorder~~[Recipient's recovery from a substance use disorder]~~; and

13 b. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy
14 per recipient~~[individual]~~ unless additional time is medically necessary.

15 4. Family outpatient therapy shall be provided by:

16 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

17 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
18 of this section.

19 (l)1. Collateral outpatient therapy shall:

20 a. Consist of a face-to-face or appropriate telehealth, provided pursuant to 907 KAR 3:170,
21 behavioral health consultation:

22 (i) With a parent or caregiver of a recipient, household member of a recipient, legal
23 representative of a recipient~~[recipient's representative]~~, school personnel~~[staff person]~~, treating

1 professional, or other person with custodial control or supervision of the recipient; and

2 (ii) That is provided in accordance with the recipient's plan of care; **[and]**

3 b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of
4 age; **and**

5 **c. Not exceed three (3) hours per day alone or in combination with any other outpatient**
6 **therapy per recipient unless additional time is medically necessary.**

7 2. Written consent by a parent or custodial guardian to discuss a recipient's treatment with any
8 person other than a parent or legal guardian shall be signed and filed in the recipient's health
9 record~~[Consent given to discuss a recipient's treatment with any person other than a parent or legal~~
10 ~~guardian shall be signed by the recipient or recipient's representative and filed in the recipient's~~
11 ~~health record].~~

12 3. Collateral outpatient therapy shall be provided by:

13 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

14 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
15 of this section.

16 (m)1. Screening, brief intervention, and referral to treatment for a substance use disorder shall:

17 a. Be provided face-to-face or via telehealth as appropriate according to 907 KAR 3:170;

18 b.~~[1.]~~ Be an evidence-based early-intervention approach for an individual with non-dependent
19 substance use ~~[in order]~~ to provide an effective strategy for intervention prior to the need for more
20 extensive or specialized treatment; and

21 c.~~[2.]~~ Consist of:

22 (i)~~[a.]~~ Using a standardized screening tool to assess an individual for risky substance use
23 behavior;

1 (ii)[b-] Engaging a recipient, who demonstrates risky substance use behavior, in a short
2 conversation and providing feedback and advice[~~to the recipient~~]; and

3 (iii)[e-] Referring a recipient to additional substance use disorder services if the recipient is
4 determined to need additional services to address [~~the recipient's~~] substance use.

5 2. A screening and brief intervention that does not meet criteria for referral to treatment may be
6 subject to coverage by the department.

7 3. A screening, brief intervention, and referral to treatment for a substance use disorder shall be
8 provided by:

9 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

10 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
11 of this section.

12 (n)1. Service planning shall:

13 a. Be provided face-to-face, or via telehealth as appropriate pursuant to the most current
14 version of The ASAM Criteria and 907 KAR 3:170;

15 b. Involve assisting a recipient in creating an individualized plan for services and developing
16 measurable goals and objectives needed for maximum reduction of the effects of a substance use
17 disorder or co-occurring disorders;

18 c. Involve restoring a recipient's functional level to the recipient's best possible functional level;
19 and

20 d. Be performed using a person-centered planning process.

21 2. A service plan:

22 a. Shall be directed and signed by the recipient;

23 b. Shall include practitioners of the recipient's choosing; and

1 c. May include:

2 (i) A mental health advance directive being filed with a local hospital;

3 (ii) A crisis plan; or

4 (iii) A relapse prevention strategy or plan.

5 3. Service planning shall be provided by:

6 a. An approved behavioral health practitioner, as limited by subsection (1) of this section; or

7 b. An approved behavioral health practitioner under supervision, as limited by subsection (1)
8 of this section.

9 (o)1. Ambulatory withdrawal management services shall:

10 a. Be provided face-to-face for recipients with a substance use disorder or co-occurring
11 disorders;

12 b. Be incorporated into a recipient's care as appropriate according to the continuum of care
13 described in the most current version of The ASAM Criteria; and

14 c. Be in accordance with the most current version of The ASAM Criteria for ambulatory
15 withdrawal management levels in an outpatient setting.

16 2. A recipient who is receiving ambulatory withdrawal management services shall:

17 a. Meet the most current **version[edition]** of diagnostic criteria for substance withdrawal
18 management found in the Diagnostic and Statistical Manual of Mental Disorders; and

19 b. Meet the current dimensional admissions criteria for withdrawal management level of care
20 as found in **the most current version of** The ASAM Criteria.

21 3. Ambulatory withdrawal management services shall be provided by:

22 a. A physician;

23 b. A psychiatrist;

- 1 c. A physician assistant;
- 2 d. An advanced practice registered nurse; or
- 3 e. Any other approved behavioral health practitioner with oversight by a physician, advanced
- 4 practice registered nurse, or a physician assistant, as limited by subsection (1) of this section.

5 (p)1. Medication assisted treatment shall be provided by an authorized prescribing provider
6 who:

7 a. Is:

8 (i) A physician licensed to practice medicine under KRS Chapter 311;

9 (ii) An advanced practice registered nurse (APRN); or

10 (iii) A physician assistant **licensed to practice medicine under KRS Chapter 311**~~who has~~
11 **appropriately updated department provider enrollment information**];

12 b. Meets standards in accordance with 201 KAR 9:270 or 201 KAR 20:065;

13 c. Maintains a current waiver under 21 U.S.C. 823(g)(2) to prescribe buprenorphine products,
14 **including any waiving or expansion of buprenorphine prescribing authority by the federal**
15 **government; and**

16 d. Has experience and knowledge in addiction medicine.

17 2. Medication assisted treatment with behavioral health therapies shall:

18 a. Be co-located within the same practicing site as the practitioner with a waiver pursuant to
19 subparagraph 1.b. of this paragraph or be conducted via telehealth as appropriate according to 907
20 KAR 3:170; or

21 b. Be conducted with agreements in place for linkage to appropriate behavioral health treatment
22 providers who specialize in substance use disorders and are knowledgeable in biopsychosocial
23 dimensions of alcohol or other substance use disorder, such as:

1 (i) An approved behavioral health practitioner, as limited by subsection (1) of this section; or

2 (ii) A multi-specialty group or behavioral health provider group pursuant to 907 KAR 15:010.

3 3. A medication assisted treatment program shall:

4 a. Assess the need for treatment including:

5 (i) A full patient history to determine the severity of the patient's substance use disorder; and

6 (ii) Identifying and addressing any underlying or co-occurring diseases or conditions, as
7 necessary;

8 b. Educate the patient about how the medication works, including:

9 (i) The associated risks and benefits; and

10 (ii) Overdose prevention;

11 c. Evaluate the need for medically managed withdrawal from substances;

12 d. Refer patients for higher levels of care if necessary; and

13 e. Obtain informed consent prior to integrating pharmacologic or nonpharmacologic therapies.

14 4. Medication assisted treatment shall be provided by:

15 a. A physician;

16 b. A psychiatrist;

17 c. An advanced practice registered nurse; or

18 d. An approved behavioral health practitioner, as limited pursuant to subsection (1) of this
19 section, or approved behavioral health practitioner under supervision, as limited pursuant to
20 subsection (1) of this section, to provide counseling, behavioral therapies, and other support
21 components with experience and knowledge in addiction medicine.

22 (q)1. An inpatient chemical dependency treatment program shall:

23 a. Be a structured inpatient program to provide medical, social, diagnostic, and treatment

1 services to individuals with substance use disorder or co-occurring disorders;

2 **b.(i) If being provided as an ASAM 3.7 level of care medically monitored intensive**
3 **inpatient service, be provided face-to-face, twenty-four (24) hours per day, seven (7) days per**
4 **week, 365 days a year with continuous nursing services and under the medical direction of a**
5 **physician; or**

6 **(ii) If being provided as an ASAM 3.5 level of care clinically managed high intensity**
7 **residential service, be provided face-to-face, or via telehealth as appropriate pursuant to the**
8 **most current version of The ASAM Criteria and 907 KAR 3:170, twenty-four (24) hours per**
9 **day, seven (7) days per week, and 365 days a year; and**

10 c. Meet the service criteria for medically monitored intensive inpatient services using **the most**
11 **current version of The ASAM Criteria, currently described by ASAM as a 3.7 level of care;**
12 and

13 d. Include the following services:

14 (i) Screening;

15 (ii) Assessment;

16 (iii) Service planning;

17 (iv) Psychiatric services;

18 (v) Individual therapy;

19 (vi) Family therapy;

20 (vii) Group therapy;

21 (viii) Peer support;

22 (ix) Medication assisted treatment; ~~or~~

23 **(x) Clinically managed high intensity residential services, as established pursuant to**

1 **subparagraph 2. of this paragraph; or**

2 **(xi) Medically monitored inpatient withdrawal management, as established pursuant to**
3 **subparagraph 3.~~2.~~ of this paragraph.**

4 **2. Clinically managed high intensity residential services provided in an inpatient chemical**
5 **dependency treatment center shall:**

6 **a. Meet the service criteria for clinically managed high intensity residential services using**
7 **the current version of The ASAM Criteria, currently described by ASAM as a 3.5 level of**
8 **care;**

9 **b. Have:**

10 **(i) A planned and structured regimen of twenty-four (24) hour professionally directed**
11 **evaluation, observation, clinical management, and addiction treatment;**

12 **(ii) Twenty-four (24) hour access to nursing care;**

13 **(iii) Twenty-four (24) hour access to a psychiatrist; and**

14 **(iv) Twenty-four (24) hour access to a physician; and**

15 **c. Comply with services pursuant to the requirements of 902 KAR 20:160, 908 KAR 1:370,**
16 **and 908 KAR 1:372, as applicable to the current version of the ASAM 3.5 level of care.**

17 **3. Medically monitored inpatient withdrawal management services provided in an inpatient**
18 **chemical dependency treatment center shall:**

19 **a. Meet the service criteria for medically monitored inpatient withdrawal management services**
20 **using the current version[~~edition~~] of The ASAM Criteria, currently described by ASAM as a**
21 **3.7 level of care; and**

22 **b. Have:**

23 **(i) A planned and structured regimen of twenty-four (24) hour professionally directed**

1 **evaluation, observation, medical monitoring, and addiction treatment;**

2 **(ii) Twenty-four (24) hour nursing care;**

3 **(iii) Twenty-four (24) hour access to a psychiatrist; and**

4 **(iv) Twenty-four (24) hour access to a physician; and**

5 **c.[b.] Comply with services pursuant to the requirements of 902 KAR 20:160.**

6 **4. An inpatient chemical dependency treatment program providing both ASAM 3.5 and**

7 **ASAM 3.7 level of care services in the same facility shall:**

8 **a. Provide the ASAM 3.7 services within a separate unit from the ASAM 3.5 level of care**

9 **unit; and**

10 **b. Meet the requirements of subparagraph 3. of this paragraph for all ASAM 3.7 level of**

11 **care services[20:111].**

12 **5.[3.] For a recipient in an inpatient chemical dependency treatment program, care coordination**
13 **shall include at minimum:**

14 **a. Facilitating medication assisted treatment for recipients as necessary, per recipient choice;**

15 **b. Referral to appropriate community services;**

16 **c. Facilitation of medical and behavioral health follow ups; and**

17 **d. Linking the recipient to the appropriate level of substance use treatment within the continuum**

18 **to provide ongoing supports.**

19 **6.[4.] Inpatient chemical dependency treatment services shall be provided in accordance with**

20 **902 KAR 20:160, Sections 4 and 7.**

21 **7.[5.] Length-of-stay for chemical dependency treatment services shall be person-centered and**

22 **according to an individually designed plan of care that is consistent with this administrative**

23 **regulation and the licensure of the facility and practitioner.**

1 8.[6.]a. Except as established in clause b. or c. of this subparagraph, the physical structure in
2 which inpatient chemical dependency treatment services is provided shall:

3 (i) Have between nine (9) and sixteen (16) beds; and

4 (ii) Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds
5 in aggregate, **except as allowed pursuant to subparagraphs 2., 3., and 4. of this paragraph and**
6 **by 902 KAR 20:160, as applicable.**

7 b. If every recipient receiving services in the physical structure is under the age of twenty-one
8 (21) years or over the age of sixty-five (65) years, the limit of sixteen (16) beds established in
9 clause a. of this subparagraph shall not apply.

10 c. The limit of sixteen (16) beds established in clause a. of this subparagraph shall not apply if
11 the facility possesses the appropriate inpatient, **or residential, as applicable, ASAM certification**
12 to provide chemical dependency treatment center services, with the exception that:

13 (i) Each currently enrolled chemical dependency treatment center shall be granted a one (1)
14 time provisional certification that expires July 1, **2022[2021]**, unless extended by the department;
15 or

16 (ii) A federal waiver, or other change to controlling federal law that allows for the availability
17 of federal financial participation, shall be available for this clause to be operational.

18 9.[7.] Inpatient chemical dependency treatment services shall not include:

19 a. Room and board;

20 b. Educational services;

21 c. Vocational services;

22 d. Job training services;

23 e. Habilitation services;

1 f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

2 g. Services to an individual residing in an institution for mental diseases pursuant to 42
3 C.F.R. 435.1010;

4 h. Recreational activities;

5 i. Social activities; or

6 j. Services required to be covered elsewhere in the Medicaid state plan.

7 **10.[8.] To provide inpatient chemical dependency treatment services, the program shall:**

8 a. Have the capacity to employ staff authorized to provide services in accordance with this
9 section and to coordinate the provision of services among team members;

10 b. Be licensed as a chemical dependency treatment services and facility in accordance with 902
11 KAR 20:160; and

12 c. After July 1, ~~2022~~**2021**, possess an appropriate ASAM Level of Care Certification for
13 medically monitored intensive inpatient services in accordance with **the most current version of**
14 **The ASAM Criteria, and possess an appropriate ASAM Level of Care Certification for**
15 **clinically managed high intensity residential services pursuant to the most current version**
16 **of The ASAM Criteria if providing that level of care.**

17 **11.[9.]a. Inpatient chemical dependency treatment shall be provided by:**

18 (i) An approved behavioral health practitioner, except as provided pursuant to subsection (1) of
19 this section; or

20 (ii) An approved behavioral health practitioner under supervision, except as provided pursuant
21 to subsection (1) of this section.

22 b. Support services for inpatient chemical dependency shall be provided by a peer support
23 specialist under the supervision of an approved behavioral health practitioner.

1 (4)~~[The extent and type of a screening shall depend upon the nature of the problem of the~~
2 ~~individual seeking or being referred for services.~~

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

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

8 Section 4. Additional Limits and Non-covered Services or Activities. (1)(a) Except as
9 established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the
10 recipient's health record within three (3) visits, the service shall not be covered.

11 (b) The requirement established in paragraph (a) of this subsection shall not apply to:

- 12 1. Mobile crisis services;
- 13 2. Crisis intervention;
- 14 3. A screening; or
- 15 4. An assessment.

16 (2) The department shall not reimburse for both a screening and a screening, brief intervention
17 and referral to treatment (SBIRT)~~[an SBIRT]~~ provided to a recipient on the same date of service.

18 (3) The following services or activities shall not be covered under this administrative regulation:

19 (a) A service provided to:

- 20 1. A resident of:
 - 21 a. A nursing facility; or
 - 22 b. An intermediate care facility for individuals with an intellectual disability;
- 23 2. An inmate of a federal, local, or state:

1 a. Jail;

2 b. Detention center; or

3 c. Prison; or

4 3. An individual with an intellectual disability without documentation of an additional
5 psychiatric diagnosis;

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

7 (c) A telephone call, an email, a text message, or other electronic contact that does not meet the
8 requirements stated in the definition of "face-to-face" established in 907 KAR 15:005, Section
9 1(21). Contact that is not reimbursable under this paragraph may be permissible if it is conducted
10 in the course of a telehealth service permitted pursuant to 907 KAR 3:170 or this administrative
11 regulation, as applicable~~(14)~~;

12 (d) Travel time;

13 (e) A field trip;

14 (f) A recreational activity;

15 (g) A social activity; or

16 (h) A physical exercise activity group.

17 (4)(a) A consultation by one (1) provider or professional with another shall not be covered
18 under this administrative regulation except as established in Section 3(3)(1)1₂ of this administrative
19 regulation.

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

21 (5) A billing supervisor arrangement between a billing supervisor and an approved~~[a]~~
22 behavioral health practitioner under supervision shall not:

23 (a) Violate the clinical supervision rules or policies of the respective professional licensure

1 boards governing the billing supervisor and the approved behavioral health practitioner under
2 supervision; or

3 (b) Substitute for the clinical supervision rules or policies of the respective professional
4 licensure boards governing the billing supervisor and the approved behavioral health practitioner
5 under supervision.

6 Section 5. No Duplication of Service. (1) The department shall not reimburse for a service
7 provided to a recipient by more than one (1) provider, of any program in which the same service
8 is covered, during the same time period.

9 (2) For example, if a recipient is receiving a behavioral health service from an independent
10 behavioral health provider, the department shall not reimburse for the same service provided to the
11 same recipient during the same time period by a chemical dependency treatment center.

12 Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A chemical
13 dependency treatment center shall maintain a current health record for each recipient.

14 (2) A health record shall document each service provided to the recipient including the date of
15 the service and the signature of the individual who provided the service.

16 (3) A health record shall:

17 (a) Include:

18 1. An identification and intake record including:

19 a. Name;

20 b. Social Security number;

21 c. Date of intake;

22 d. Home (legal) address;

23 e. Health insurance or Medicaid participation information;

- 1 f. If applicable, the referral source's name and address;
- 2 g. Primary care physician's name and address;
- 3 h. The reason the individual is seeking help including the presenting problem and diagnosis;
- 4 i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and
5 information regarding:
 - 6 (i) Where the individual is receiving treatment for the physical health diagnosis; and
 - 7 (ii) The physical health provider's name; and
- 8 j. The name of the informant and any other information deemed necessary by the chemical
9 dependency treatment center in order to comply with the requirements of:
 - 10 (i) This administrative regulation;
 - 11 (ii) The chemical dependency treatment center's licensure board;
 - 12 (iii) State law; or
 - 13 (iv) Federal law;
- 14 2. Documentation of the:
 - 15 a. Screening;
 - 16 b. Assessment, if an assessment was performed; and
 - 17 c. Disposition, if a disposition was performed;
- 18 3. A complete history including mental status and previous treatment;
- 19 4. An identification sheet;
- 20 5. A consent for treatment sheet that is accurately signed and dated; and
- 21 6. The individual's stated purpose for seeking services; and
- 22 (b) Be:
 - 23 1. Maintained in an organized central file;

1 2. Furnished upon request:

2 a. To the Cabinet for Health and Family Services; or

3 b. For an enrollee, to the managed care organization in which the recipient is enrolled or has
4 been enrolled in the past;

5 3. Made available for inspection and copying by:

6 a. Cabinet for Health and Family Services' personnel; or

7 b. Personnel of the managed care organization in which the recipient is enrolled if applicable;

8 4. Readily accessible; and

9 5. Adequate for the purpose of establishing the current treatment modality and progress of the
10 recipient if the recipient received services beyond a screening.

11 (4) Documentation of a screening shall include:

12 (a) Information relative to the individual's stated request for services; and

13 (b) Other stated personal or health concerns if other concerns are stated.

14 (5)(a) A chemical dependency treatment center's service notes regarding a recipient shall:

15 1. Be made within forty-eight (48) hours of each service visit; [~~and~~]

16 2. Indicate if the service was provided face-to-face or via telehealth for outpatient services; and

17 3. Describe the:

18 a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

19 b. Behavioral health practitioner's intervention;

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

21 d. Need for continued treatment if deemed necessary.

22 (b)1. Any edit to notes shall:

23 a. Clearly display the changes; and

1 b. Be initialed and dated by the person who edited the notes.

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

3 (c)1. Notes recorded by an approved[a] behavioral health practitioner [~~working~~] under
4 supervision shall be co-signed and dated by the supervising professional within thirty (30) days.

5 2. If services are provided by an approved[a] behavioral health practitioner [~~working~~] under
6 supervision, there shall be a monthly supervisory note recorded by the supervising professional
7 that[~~which~~] reflects consultations with the approved behavioral health practitioner working under
8 supervision concerning the:

9 a. Case; and

10 b. Supervising professional's evaluation of the services being provided to the recipient.

11 (6) Immediately following a screening of a recipient, the practitioner shall perform a disposition
12 related to:

13 (a) A provisional diagnosis;

14 (b) A referral for further consultation and disposition, if applicable; or

15 (c)1. If applicable, termination of services and referral to an outside source for further services;

16 or

17 2. If applicable, termination of services without a referral to further services.

18 (7) Any change to a recipient's plan of care shall be documented, signed, and dated by the
19 rendering practitioner and by the recipient or recipient's representative.

20 (8)(a) Notes regarding services to a recipient shall:

21 1. Be organized in chronological order;

22 2. Be dated;

23 3. Be titled to indicate the service rendered;

1 4. State a starting and ending time for the service; and

2 5. Be recorded and signed by the rendering practitioner and include the professional title (for
3 example, licensed clinical social worker) of the provider.

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

5 (c) Telephone contacts, family collateral contacts not covered under this administrative
6 regulation, or other non-reimbursable contacts shall:

7 1. Be recorded in the notes; and

8 2. Not be reimbursable.

9 (9)(a) A termination summary shall:

10 1. Be required, upon termination of services, for each recipient who received at least three (3)
11 service visits; and

12 2. Contain a summary of the significant findings and events during the course of treatment
13 including the:

14 a. Final assessment regarding the progress of the individual toward reaching goals and
15 objectives established in the individual's plan of care;

16 b. Final diagnosis of clinical impression; and

17 c. Individual's condition upon termination and disposition.

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

20 (10) If an individual's case is reopened within ninety (90) days of terminating services for the
21 same or related issue, a reference to the prior case history with a note regarding the interval period
22 shall be acceptable.

23 (11)(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or

1 referred to a health care facility or other provider for care or treatment, the transferring chemical
2 dependency treatment center shall, within ten (10) business days of awareness of the transfer or
3 referral, transfer the recipient's records in a manner that complies with the records' use and
4 disclosure requirements as established in or required by:

5 1.a. The Health Insurance Portability and Accountability Act;

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

7 c. 45 C.F.R. Parts 160 and 164; or

8 2.a. 42 U.S.C. 290ee-3; and

9 b. 42 C.F.R. Part 2.

10 (b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric
11 hospital, a psychiatric distinct part unit in an acute care hospital, a Level I psychiatric residential
12 treatment facility, a Level II psychiatric residential treatment facility, or an acute care hospital for
13 care or treatment, the transferring chemical dependency treatment center shall, within forty-eight
14 (48) hours of the transfer or referral, transfer the recipient's records in a manner that complies with
15 the records' use and disclosure requirements as established in or required by:

16 1.a. The Health Insurance Portability and Accountability Act;

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

18 c. 45 C.F.R. Parts 160 and 164; or

19 2.a. 42 U.S.C. 290ee-3; and

20 b. 42 C.F.R. Part 2.

21 (12)(a) If a chemical dependency treatment center's Medicaid Program participation status
22 changes as a result of voluntarily terminating from the Medicaid Program, involuntarily
23 terminating from the Medicaid Program, a licensure suspension, or death of an owner or deaths of

1 owners, the health records of the chemical dependency treatment center shall:

- 2 1. Remain the property of the chemical dependency treatment center; and
- 3 2. Be subject to the retention requirements established in subsection (13) of this section.

4 (b) A chemical dependency treatment center shall have a written plan addressing how to
5 maintain health records in the event of death of an owner or deaths of owners.

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

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

- 11 1. Six (6) years unless the recipient is a minor; or
- 12 2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under
13 state law.

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

17 (14)(a) A chemical dependency treatment center shall comply with 45 C.F.R. Part 164.

18 (b) All information contained in a health record shall:

- 19 1. Be treated as confidential;
- 20 2. Not be disclosed to an unauthorized individual; and
- 21 3. Be disclosed to an authorized representative of:
 - 22 a. The department;
 - 23 b. Federal government; or

1 c. For an enrollee, the managed care organization in which the enrollee is enrolled.

2 (c)1. Upon request, a chemical dependency treatment center shall provide to an authorized
3 representative of the department, federal government, or managed care organization if applicable,
4 information requested to substantiate:

5 a. Staff notes detailing a service that was rendered;

6 b. The professional who rendered a service; and

7 c. The type of service rendered and any other requested information necessary to determine, on
8 an individual basis, whether the service is reimbursable by the department or the managed care
9 organization, if applicable.

10 2. Failure to provide information referenced in subparagraph 1. of this paragraph shall result in
11 denial of payment for any service associated with the requested information.

12 Section 7. Medicaid Program Participation Compliance. (1) A chemical dependency treatment
13 center shall comply with:

14 (a) 907 KAR 1:671;

15 (b) 907 KAR 1:672; and

16 (c) All applicable state and federal laws.

17 (2)(a) If a chemical dependency treatment center receives any duplicate payment or
18 overpayment from the department or a managed care organization, regardless of reason, the
19 chemical dependency treatment center shall return the payment to the department or managed care
20 organization in accordance with 907 KAR 1:671.

21 (b) Failure to return a payment to the department or managed care organization in accordance
22 with paragraph (a) of this subsection may be:

23 1. Interpreted to be fraud or abuse; and

1 2. Prosecuted in accordance with applicable federal or state law.

2 (3)(a) When the department makes payment for a covered service and the chemical dependency
3 treatment center accepts the payment:

4 1. The payment shall be considered payment in full;

5 2. A bill for the same service shall not be given to the recipient; and

6 3. Payment from the recipient for the same service shall not be accepted by the chemical
7 dependency treatment center.

8 (b)1. A chemical dependency treatment center may bill a recipient for a service that is not
9 covered by the Kentucky Medicaid Program if the:

10 a. Recipient requests the service; and

11 b. Chemical dependency treatment center makes the recipient aware in writing in advance of
12 providing the service that the:

13 (i) Recipient is liable for the payment; and

14 (ii) Department is not covering the service.

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

17 a. Chemical dependency treatment center shall not bill the department for the service; and

18 b. Department shall not:

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

20 (ii) Make any payment to the chemical dependency treatment center regarding the service.

21 (4)(a) A chemical dependency treatment center shall attest by the chemical dependency
22 treatment center's staff's or representative's signature that any claim associated with a service is
23 valid and submitted in good faith.

1 (b) Any claim and substantiating record associated with a service shall be subject to audit by
2 the:

- 3 1. Department or its designee;
- 4 2. Cabinet for Health and Family Services, Office of Inspector General, or its designee;
- 5 3. Kentucky Office of Attorney General or its designee;
- 6 4. Kentucky Office of the Auditor for Public Accounts or its designee;
- 7 5. United States General Accounting Office or its designee; or
- 8 6. For an enrollee, managed care organization in which the enrollee is enrolled.

9 (c)1. If a chemical dependency treatment center receives a request from the:

10 a. Department to provide a claim, related information, related documentation, or record for
11 auditing purposes, the chemical dependency treatment center shall provide the requested
12 information to the department within the timeframe requested by the department; or

13 b. Managed care organization in which an enrollee is enrolled to provide a claim, related
14 information, related documentation, or record for auditing purposes, the chemical dependency
15 treatment center shall provide the requested information to the managed care organization within
16 the timeframe requested by the managed care organization.

17 2.a. The timeframe requested by the department or managed care organization for a chemical
18 dependency treatment center to provide requested information shall be:

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

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

22 b. A chemical dependency treatment center may request a longer timeframe to provide
23 information to the department or a managed care organization if the chemical dependency

1 treatment center justifies the need for a longer timeframe.

2 (d)1. All services provided shall be subject to review for recipient or provider fraud or abuse,
3 and compliance with this administrative regulation and state and federal law.

4 2. Willful abuse by a chemical dependency treatment center shall result in the suspension or
5 termination of the chemical dependency treatment center from Medicaid Program participation in
6 accordance with 907 KAR 1:671.

7 Section 8. Third Party Liability. A chemical dependency treatment center shall comply with
8 KRS 205.622.

9 Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use
10 of electronic signatures and documents shall comply with the requirements established in KRS
11 369.101 to 369.120.

12 (2) A chemical dependency treatment center that chooses to use electronic signatures shall:

13 (a) Develop and implement a written security policy that shall:

14 1. Be adhered to by each of the chemical dependency treatment center's employees, officers,
15 agents, or contractors;

16 2. Identify each electronic signature for which an individual has access; and

17 3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

18 (b) Develop a consent form that shall:

19 1. Be completed and executed by each individual using an electronic signature;

20 2. Attest to the signature's authenticity; and

21 3. Include a statement indicating that the individual has been notified of his or her responsibility
22 in allowing the use of the electronic signature; and

23 (c) Provide the department, immediately upon request, with:

- 1 1. A copy of the chemical dependency treatment center's electronic signature policy;
- 2 2. The signed consent form; and
- 3 3. The original filed signature.

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

- 6 (1) Claim;
- 7 (2) Health record; or
- 8 (3) Documentation associated with any claim or health record.

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

- 11 (a) Receipt of federal financial participation for the coverage; and
 - 12 (b) Centers for Medicare and Medicaid Services' approval for the coverage.
- 13 (2) The reimbursement of services provided by a licensed clinical alcohol and drug counselor
14 or licensed clinical alcohol and drug counselor associate shall be contingent and effective upon
15 approval by the Centers for Medicare and Medicaid Services.

16 Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service
17 and a recipient who is not enrolled with a managed care organization shall be in accordance with
18 907 KAR 1:563.

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

907 KAR 15:080

REVIEWED:

February 10, 2021
Date



Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

2/11/2021
Date

DocuSigned by:
Eric Friedlander
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Eric Friedlander, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 15:080

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program outpatient and inpatient chemical dependency treatment center (CDTC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal mandates. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments to this administrative regulation combine a previously separate description of who may perform a service and a description of the service itself. This series of amendments also includes a reference to the defined terms "approved behavioral health practitioner" and "approved behavioral health practitioner under supervision" from 907 KAR 15:005 instead of a listing of each provider in each service. This provides for more transparency and compactness in the administrative regulation. The administrative regulation has also clarified the use of telehealth in several places. Additional requirements relating to mobile crisis services include requiring access to a board-certified or board eligible psychiatrist at all times, and allowing for the use of peer support specialists. Day treatment services include additional requirements relating to staff qualifications. Peer support specialist services are amended to further allow and enhance the use of emergency department bridge clinics. In addition, peer support specialist services are now required to only be 30 hours per week of direct recipient contact and group peer support services are not allowed to exceed 8 individuals within any group at one time. Intensive outpatient program services are required to comply with the most current service criteria of the ASAM Criteria, and additional clarification is given about how the services are to be provided to adults and adolescents. The amendments also include new services and requirements relating to "service planning", "ambulatory withdrawal management", "medication assisted treatment", and "inpatient chemical dependency treatment".

The Amended After Comments version of this administrative regulation is amended to potentially allow additional services to utilize telehealth, if acceptable pursuant to the ASAM Criteria, and 907 KAR 3:170. The administrative regulation additionally clarifies how collateral therapy is to be utilized on days that other outpatient therapies are provided. The administrative regulation also updates references to physician assistants, and allows for the potential for expanded prescribing authority of buprenorphine products. Finally, the administrative regulation also allows for an ASAM 3.5 level of care to be provided within a CDTC that provides SUD withdrawal, if the CDTC has an ASAM 3.5 certification.

(b) The necessity of the amendment to this administrative regulation: These amendments are necessary to comply with existing OIG administrative regulations, implement an SUD 1115 waiver, require compliance with the ASAM Criteria, and provide additional formatting improvements.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments conform to the content of the authorizing statutes by implementing an SUD 1115 waiver.

(d) How the amendment will assist in the effective administration of the statutes: The amendments will assist in the effective administration of the statutes by providing additional clarity and requirements relating to chemical dependency treatment centers.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities licensed as chemical dependency treatment centers (CDTCs), behavioral health professionals authorized to provide services in CDTCs, and Medicaid recipients who receive services in CDTCs will be affected by the administrative regulation. Currently there are 3 CDTC licenses issued by the state.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Entities that qualify as chemical dependency treatment centers and who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete an application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The entities referenced in paragraph (a) could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The entities referenced in paragraph (a) will benefit by receiving Medicaid Program reimbursement for providing behavioral health services to Medicaid recipients. Behavioral health professionals authorized to provide services in a chemical dependency treatment center will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS anticipates potential savings of more than \$4.6 million due to the availability of a level of care that is less expensive than hospitalization via the introduction of inpatient chemical dependency treatment centers.

(b) On a continuing basis: DMS anticipates potential savings of more than \$4.6 million due to the availability of a level of care that is less expensive than hospitalization via the introduction of inpatient chemical dependency treatment centers.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 907 KAR 15:080

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSregs@ky.gov

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23) is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency that oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid). Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation #: 907 KAR 15:080

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSregs@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates potential savings of more than \$4.6 million due to the availability of a level of care that is less expensive than hospitalization via the introduction of inpatient chemical dependency treatment centers.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates potential savings of more than \$4.6 million due to the availability of a level of care that is less expensive than hospitalization via the introduction of inpatient chemical dependency treatment centers.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 15:080

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations

Amended After Comments

I. A public hearing on 907 KAR 15:080 was not requested, and therefore, not held. However, written comments were received during the public comment period.

II. The following individuals submitted comments during the public comment period:

<u>Name and Title</u>	<u>Agency/Organization/Entity/Other</u>
Steve Shannon, Executive Director	Kentucky Association of Regional Programs
Sheila Schuster, PhD, Executive Director	Kentucky Mental Health Coalition
Rebecca Randall, Senior Director of Operations	WellCare Health Plans of Kentucky
Kathy Adams, Director of Public Policy	Children's Alliance
Adam Haley, Executive Director	Kentucky Academy of Physician Assistants
Holly Turner Curry	Cull and Hayden
Marie Alagia Cull	Cull and Hayden
Ann Hollen, Senior Behavioral Health Advisor	Department for Medicaid Services
Leigh Ann Fitzpatrick, Behavioral Health Specialist	Department for Medicaid Services
Sherry Staley, Behavioral Health Specialist	Department for Medicaid Services
Angela Sparrow, Behavioral Health Specialist	Department for Medicaid Services

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 15:080:

<u>Name and Title</u>	<u>Agency/Organization/Entity/Other</u>
Lisa Lee, Commissioner	Department for Medicaid Services, Commissioner's Office
Veronica Cecil, Senior Deputy Commissioner	Department for Medicaid Services, Commissioner's Office

Leslie Hoffman, Chief Behavioral Health Officer	Department for Medicaid Services, Commissioner's Office
Lee Guice, Director	Department for Medicaid Services Division of Policy and Operations,
Ann Hollen, Senior Behavioral Health Policy Advisor	Department for Medicaid Services Division of Policy and Operations
Angela Sparrow, Behavioral Health Specialist	Department for Medicaid Services Division of Policy and Operations
Sherri Staley, Behavioral Health Specialist	Department for Medicaid Services Division of Policy and Operations
Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services, Commissioner's Office

IV. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Change of title and usage of term "substance use disorder" in place of "chemical dependency"

(a) Comment: Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments requesting that all instances of the term "chemical dependency" be replaced with the term "substance use disorder" to reflect the current terminology used in the field.

(b) Response: DMS is sympathetic to this request and prefers to utilize current terminology whenever possible. However, the term "chemical dependency" is located throughout the Medicaid state plan, facility licensing statutes located in KRS Chapter 216B, and in the administrative regulations of other state agencies. Because of this, the term "chemical dependency treatment center" is highly defined and regulated in state law and federal agreement in ways that DMS cannot modify in only this administrative regulation. The result of changing the term "chemical dependency" to "substance use disorder" would be to detach the statutory and regulatory authority for this administrative regulation as it relates to chemical dependency treatment centers. As a result, DMS is not comfortable making that change at this time. The administrative regulation will not be amended in response to the comment.

(2) Subject: Allow applied behavior analysis (ABA) therapy as a service within this administrative regulation.

(a) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance, submitted comments requesting that ABA therapy be added as a service to this administrative regulation. The comment highlights the value that this intervention could have for the population served by this administrative regulation.

(b) Response: DMS is sympathetic to this possibility and will take it under advisement. However, expanding ABA therapy to this population would require a state plan amendment. Furthermore, from DMS' perspective, ABA therapy is at the beginning of an expansion into

SUD treatment. DMS plans to study and assess the possibility of expansion of ABA therapy and treatment success and outcomes over a longer timeframe. The administrative regulation will not be amended in response to the comment.

(3) Subject: Removal of face-to-face restrictions for certain services.

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, and Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments requesting that telehealth be allowed in the following services: individual therapy, group therapy, and family therapy.

(a) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance, submitted comments requesting that telehealth be allowed in the following services: mobile crisis services, day treatment, peer support, intensive outpatient services, service planning, and group outpatient therapy.

(b) Response: The department intends to modify 907 KAR 3:170 to apply to all telehealth services, including any services that are currently face-to-face within 907 KAR Chapter 15. During the current state of emergency, these services have been able to be delivered via telehealth. DMS will amend this administrative regulation to clarify that if 907 KAR 3:170 allows, then these services may be delivered via telehealth. Another important consideration, especially given the seriousness of a condition requiring an ASAM 3.7 level of care, is to ensure that this is clinically appropriate. DMS expects providers – and MCOs – to be aware of scenarios involving these expanded services in which telehealth is not appropriate or safe for patients.

Finally, it is important to note that even if a telehealth service is delivered, it cannot be separately billed from a per diem rate, if applicable. The administrative regulation will be amended in response to these comments.

(4) Subject: Improvement of physician assistant medication assisted treatment reference.

(a) Comment: Adam Haley, Executive Director of the Kentucky Academy of Physician Assistants, and Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments requesting more clarity in describing the medication assisted treatment authority of physician assistants.

(b) Response: The department agrees with this comment and will modify this administrative regulation in Section 3(2)(p)1.a.(iii) to state “A physician assistant licensed to practice medicine under KRS Chapter 311”.

(5) Subject: Importance of effective, accessible, and inclusive substance use disorder treatment

(a) Comment: Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments discussing the importance of Kentucky’s expanded substance use disorder treatment, and how SUD treatment is a critically important issue for the Commonwealth to successfully address.

(b) Response: The department agrees with these comments and is committed to expanding and ensuring broad availability of evidence-based SUD treatment to all beneficiaries. The administrative regulation will not be amended in response to the comment.

(6) Subject: Inpatient medical detoxification services within the CDTC setting

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments addressing Wellcare's understanding that CDTCs are not allowed to provide "medical detoxification" and requesting further clarification within this administrative regulation.

(a) Comment: Holly Turner Curry and Marie Alagia Cull, Law Offices of Cull and Hayden, submitted comments discussing the appropriate ASAM level of care (LOC) for CDTCs to provide. The comments argue that CDTCs should provide not only a medically monitored 3.7 ASAM LOC, but also a medically managed 4.0 ASAM LOC. These comments argue that CDTCs are currently required by 902 KAR 20:111 to provide ASAM 4.0 LOC services, even though they are only reimbursed for ASAM 3.7 LOC services by DMS.

(b) Response: The ASAM Criteria establishes what was previously termed "medical detoxification" as two different types of services. These services are called "medically managed withdrawal services" and "medically monitored withdrawal services". This administrative regulation, the state plan amendment, and the 1115 SUD Waiver explicitly only allow medically monitored inpatient services to be provided within an RCSU. Medically monitored withdrawal services are those services that meet the 3.7 Level of Care (LOC) from ASAM. Furthermore, DMS is requiring all RCSUs providing SUD treatment to receive an ASAM-CARF certification to provide ASAM 3.7 LOC medically monitored withdrawal services.

The department considers medically managed withdrawal services (those that are ASAM LOC 4.0 and higher) to be acute care services. Therefore, medically managed withdrawal services are only reimbursable at this time when provided within a hospital setting. It is DMS' understanding that ASAM LOC certifications for LOC 4.0 are not available.

In reviewing this administrative regulation, however, some confusion has resulted due to the reference to 902 KAR 20:111. At this time, 902 KAR 20:111 conflates medically managed and medically monitored withdrawal services in a way that is not reflective of modern practice, the ASAM Criteria, or Kentucky's negotiated state plan and 1115 SUD Waiver. Fortunately, 902 KAR 20:111 is not the licensure regulation for RCSUs or chemical dependency treatment centers (CDTCs). Therefore, this administrative regulation will be amended to remove the reference to 902 KAR 20:111 and to instead reference 902 KAR 20:440, which is the Office of Inspector General's licensing administrative regulation for RCSUs.

(7) Subject: Expansion of MAT prescribing by physicians due to recent federal changes.

(a) Comment: Sherri Staley, Behavioral Health Specialist, Department for Medicaid Services, submitted comments referencing a recent change in federal law relating to the relaxing of a

requirement for physicians to receive a waiver from the Drug Enforcement Administration (DEA) to prescribe buprenorphine.

(b) Response: The department agrees that this requirement has changed or may imminently change and will modify the administrative regulation to meet the potentially modifying federal standard. As DMS currently understands the changed federal authority, physicians working in specialized SUD treatment facilities, such as a Residential Crisis Stabilization Unit, may continue to need a DEA waiver in order to meaningfully serve the volume of patients that will be present in any outpatient or residential SUD treatment settings. However, this change is important, and this practice opportunity should be reflected in DMS administrative regulations, even if DMS anticipates that the most meaningful adoption of expanded buprenorphine prescribing will occur in other health settings. DMS, therefore, will endeavor to amend all behavioral health administrative regulations to comply.

However, within existing Medicaid administrative regulations, DMS further believes that providers can immediately utilize this expanded authority. First, DMS will broadly construe the Federal Approval clause located in each behavioral health administrative regulation to encompass this scenario of expanded federal authority. Second, the phrase in the administrative regulation necessarily contemplates federal regulatory authority and its associated processes. Therefore, this federal regulatory change allowing for expanded practice is included within the concept of “a current waiver under 21 U.S.C. 823(g)(2)”.

Section 3(2)(p)1.c. of this administrative regulation will be amended to include the new federal authority as follows:

c. Maintains a current waiver under 21 U.S.C 823(g)(2) to prescribe buprenorphine products, **including any waiving or expansion of buprenorphine prescribing authority by the federal government;** and

(8) Subject: Certified Alcohol and Drug Counselor Associates

(a) Comment: Rebecca Randall, Senior Director of Operations, WellCare Health Plans of Kentucky, submitted comments acknowledging the creation of two (2) new behavioral health practitioners, a certified alcohol and drug counselor associate I (CADCA I) and a certified alcohol and drug counselor associate II (CADCA II) and asking whether they would be incorporated into this administrative regulation.

(b) Response: At this time, DMS is continuing to monitor the development of this new practitioner. The licensure or certification requirements for this new practitioner are continuing to be developed by various stakeholder boards, commissions, and other CHFS agencies. At this time, DMS does not have enough guidance from licensing or certifying bodies to introduce these new practitioners into the Medicaid program. Due to the structure of 907 KAR Chapter 15, however, as this provider type evolves, DMS could integrate CADCA I and IIs into the Medicaid program by amending only the definitions administrative regulation for this chapter, 907 KAR 15:005.

(9) Subject: Screening and Brief Intervention without Referral

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments requesting clarification about coverage conditions for this type of service. In addition, a request has been made for the appropriate codes to be utilized by providers in such an occurrence.

(b) Response: DMS reimburses for members screened but who do not meet criteria for referral to treatment. DMS does have an established code listed on the DMS Behavioral Health Fee Schedule, and it is listed as follows: H0049 – Alcohol and/or Drug Screening, & Brief Intervention, less than 15 minutes. The administrative regulation will not be amended in response to the comment.

(10) Subject: Intensive Outpatient Program (IOP) limit

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments recommending that IOP be limited to four (4) hours per day, four (4) days per week.

(b) Response: DMS has established the current IOP requirements in order to align with the ASAM criteria as required by 2018's HB 124. The ASAM requirements have also been incorporated into the 1115 SUD Waiver, and the Medicaid state plan. As a result, for DMS to modify the current IOP limit, a SPA change would be required. The administrative regulation will not be amended in response to the comment.

(11) Subject: IOP and other covered services.

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments inquiring as to whether services such as peer support, individual therapy, group therapy, family therapy, and day treatment can be “unbundled” and covered on the same day that IOP is billed.

(b) Response: IOP consists of the components listed in this administrative regulation such as individual therapy, group therapy, and family therapy. These services cannot be billed on the same day that IOP is billed. This requirement similarly applies to day treatment. The administrative regulation will not be amended in response to the comment.

(12) Subject: Collateral Therapy limit

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments recommending that collateral therapy be limited to 3 hours per day in order to be consistent with other services.

(b) Response: DMS agrees with this recommendation and will include it in the administrative regulation. By default, collateral therapy is an “other outpatient therapy” and cannot exceed the 3 hour limit in combination with the others. The administrative regulation will be amended to limit

collateral outpatient therapy to 3 hours per day in order to be consistent with other services.

(13) Subject: Psychoeducation

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments recommending that this service be covered as a standalone service and provided for no more than 3 hours per day.

(b) Response: DMS is currently assessing whether psychoeducation should be covered as a standalone service. Such a change would require a state plan amendment. DMS will continue to assess and will amend Chapter 15 and other behavioral health administrative regulations as necessary at the end of this process. The administrative regulation will not be amended in response to the comment.

(14) Subject: Service Planning in residential settings

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments recommending a clarification that service planning is included within services such as residential substance use disorder treatment, residential crisis stabilization unit care, partial hospitalization, and IOP and cannot be unbundled and paid separately when rendered with these per diem services.

(b) Response: That is correct. The service planning service within this administrative regulation only refers to those CDTCs providing and those individuals receiving outpatient services. DMS will not be amending the administrative regulation in response to the comment.

(15) Subject: Add targeted case management (TCM) as a service within this administrative regulation

(a) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance, submitted comments requesting clarification about targeted case management and whether it should be included within this administrative regulation as a covered service.

(b) Response: DMS agrees that a CDTC can provide targeted case management. DMS further agrees that a CDTC providing TCM is a reimbursable Medicaid benefit. However, DMS would prefer to not include TCM as a covered service within this administrative regulation. DMS prefers to treat TCM as a separate service and utilizes a separate regulation - 907 KAR 15:040 - to establish requirements relating to targeted case management. DMS currently allows chemical dependency treatment centers to provide these services within that administrative regulation. DMS also intends to update 907 KAR 15:040 within the next year in order to better clarify requirements surrounding targeted case management. The department will not be amending the administrative regulation in response to the comment.

(16) Subject: Service name and ASAM reference updates

(a) Comment: Leigh Ann Fitzpatrick, Behavioral Health Specialist, Department for Medicaid

Services, submitted agency comments indicating that references to the ASAM criteria should be to the most current version, and not the most current edition. Also, the updating of certain service category names was requested.

(b) Response: The department agrees with these comments, and the administrative regulation will be amended.

V. SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 15:080. This administrative regulation is being amended after comments. DMS is amending the administrative regulations as follows:

Page 11

Section 3(2)(b)5.

Line 19

After "the most current", insert "version".

Delete "edition".

Page 14

Section 3(2)(e)4.

Line 2

After "a face-to-face," insert the following:

or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170,

Page 15

Section 3(2)(f)2.a.

Line 6

After "a face-to-face," insert the following:

, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170,

Page 17

Section 3(2)(g)1.d.

Line 16

After "a face-to- face," insert the following:

, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170

Page 19

Section 3(2)(h)1.c.

Line 3

After “the most current”, insert “version”.

Delete “edition”.

Page 19

Section 3(2)(h)1.d.

Line 5

After “a face-to- face”, insert the following:

, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170

Page 21

Section 3(2)(j)1.c.

Line 17

After “a face-to-face”, insert the following:

, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170,

Page 23

Section 3(2)(l)a.(ii)

Line 20

After “plan of care;”, delete “and”.

Page 23

Section 3(2)(l)b.

Lines 21-22

After “years of age”, insert the following:

; and

c. Not exceed three (3) hours per day alone or in combination with any other out-patient therapy per recipient unless additional time is medically necessary

Page 25

Section 3(2)(n)1.a.

Line 6

After “face-to-face”, insert the following:

, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170

Page 26

Section 3(2)(o)2.a.

Line 9

After “the most current”, insert “version”.

Delete “edition”.

Page 26

Section 3(2)(o)2.b.

Line 12

After “as found in”, insert the following:
the most current version of

Page 27

Section 3(2)(p)1.a.(iii)

Lines 2-3

After “A physician assistant”, insert the following:
licensed to practice medicine under KRS Chapter 311

Delete the following:

who has appropriately updated department provider enrollment information

Page 27

Section 3(2)(p)1.c.

Line 5

After “buprenorphine products”, insert the following:
, including any waiving or expansion of buprenorphine prescribing authority by the federal government

Page 28

Section 3(2)(q)1.b.

Line 16

After “b.”, insert the following:

(i) If being provided as an ASAM 3.7 level of care medically monitored intensive inpatient service.

Change the capitalization of “Be”.

Line 17

After “physician;”, insert the following:

and

(ii) If being provided as an ASAM 3.5 level of care clinically managed high intensity residential service, be provided face-to-face, or via telehealth as appropriate pursuant to the most current version of The ASAM Criteria and 907 KAR 3:170, twenty-four (24) hours per day, seven (7) days per week, and 365 days a year

Page 28

Section 3(2)(q)1.c.

Line 18

After “using”, insert the following:
the most current version of

Lines 18 and 19

After “The ASAM Criteria”, insert the following:
, currently described by ASAM as a 3.7 level of care

Page 29

Section 3(2)(q)1.d.(ix)

Line 6

After "treatment;", delete "or".

Page 29

Section 3(2)(q)1.d.(x)

Line 7

After "(x)", insert the following:

Clinically managed high intensity residential services, as established pursuant to subparagraph 2. of this paragraph; or

(xi)

Line 8

After "subparagraph", insert "3.".

Delete "2.".

Page 29

Section 3(2)(q)2.

Line 9

After "2.", insert the following:

Clinically managed high intensity residential services provided in an inpatient chemical dependency treatment center shall:

a. Meet the service criteria for clinically managed high intensity residential services using the current version of The ASAM Criteria, currently described by ASAM as a 3.5 level of care;

b. Have:

(i) A planned and structured regimen of twenty-four (24) hour professionally directed evaluation, observation, clinical management, and addiction treatment;

(ii) Twenty-four (24) hour access to nursing care;

(iii) Twenty-four (24) hour access to a psychiatrist; and

(iv) Twenty-four (24) hour access to a physician; and

c. Comply with services pursuant to the requirements of 902 KAR 20:160, 908 KAR 1:370, and 908 KAR 1:372, as applicable to the current version of the ASAM 3.5 level of care.

3.

Page 29

Section 3(2)(q)2.a.

Line 12

After "the current", insert "version".

Delete "edition".

After "The ASAM Criteria", insert the following:

, currently described by ASAM as a 3.7 level of care; and

b. Have:

(i) A planned and structured regimen of twenty-four (24) hour professionally directed evaluation, observation, medical monitoring, and addiction treatment;

- (ii) Twenty-four (24) hour nursing care;
- (iii) Twenty-four (24) hour access to a psychiatrist; and
- (iv) Twenty-four (24) hour access to a physician

Page 29

Section 3(2)(q)2.b.

Line 13

Before "b.", insert "c.".

Delete "b.".

After "902 KAR", insert the following:

20:160.

4. An inpatient chemical dependency treatment program providing both ASAM 3.5 and ASAM 3.7 level of care services in the same facility shall:

a. Provide the ASAM 3.7 services within a separate unit from the ASAM 3.5 level of care unit; and

b. Meet the requirements of subparagraph 3. of this paragraph for all ASAM 3.7 level of care services

Delete "20:111".

Page 29

Section 3(2)(q)3.

Line 14

Before "3.", insert "5.".

Delete "3.".

Page 29

Section 3(2)(q)4.

Line 21

Before "4.", insert "6.".

Delete "4.".

Page 29

Section 3(2)(q)5.

Line 23

Before "5.", insert "7.".

Delete "5.".

Page 30

Section 3(2)(q)6.

Line 3

Before "6.", insert "8.".

Delete "6.".

Page 30

Section 3(2)(q)6.a.(ii)

Line 5

After “in aggregate”, insert the following:

, except as allowed pursuant to subparagraphs 2., 3., and 4. of this paragraph and by 902 KAR 20:160, as applicable

Page 30

Section 3(2)(q)6.c.

Line 12

After “the appropriate inpatient”, insert “, or residential, as applicable.”.

Page 30

Section 3(2)(q)6.c.(i)

Line 15

After “expires July 1,”, insert “2022”.

Delete “2021”.

Page 30

Section 3(2)(q)7.

Line 18

Before “7.”, insert “9.”.

Delete “7.”

Page 31

Section 3(2)(q)8.

Line 7

Before “8.”, insert “10.”.

Delete “8.”

Page 31

Section 3(2)(q)8.c.

Line 12

After “July 1,”, insert “2022”.

Delete “2021”.

Line 13

After “in accordance with”, insert the following:

the most current version of

After “The ASAM Criteria”, insert the following:

, and possess an appropriate ASAM Level of Care Certification for clinically managed high intensity residential services pursuant to the most current version of The ASAM Criteria if providing that level of care

Page 31

Section 3(2)(q)9.

Line 14

Before "9.", insert "11.".

Delete "9."