

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

907 KAR 1:044
Material Incorporated by Reference

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Cabinet for Health and Family Services
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April 2022

SECTION	TABLE OF CONTENTS	PAGE NUMBER
I. INTRODUCTION		4
II. KENTUCKY MEDICAID PROGRAM		5-7
A. General Information		5
B. Advisory Council		5
C. Policy		5-6
D. Public Law 92-603		6-7
III. CONDITIONS OF PARTICIPATION		7-24
A. Provider		7
B. Staff		7-14
C. Billing Supervision		14-15
D. Affiliation Agreements		15-16
E. Health Records		16-
1. Identification		17
2. Screening, Evaluations, and Disposition		17
3. Staffing and Plan of Care		17-19
4. History and Examinations		19
5. Service Notes		19-20
6. Medication		20
7. Diagnosis or Clinical Impression		20-21
8. Discharge Summary		21
9. Health Record Completion		21
10. Retention of Records		21
11. Confidentiality of Records		21
F. Application for Participation		21
G. Out-of-State Facility		22-23
H. Termination of Participation		23-24
I. Definition of Telehealth		24
IV. COVERED SERVICES		25-51
Rehabilitative Mental Health and Substance Use Services		25
1. General Information		25
2. Individual Outpatient Therapy		25
3. Group Outpatient Therapy		26
4. Family Outpatient Therapy		26
5. Collateral Outpatient Therapy		26-27
6. Crisis Intervention Services		27

Cabinet for Health and Family Services
 Department for Medicaid Services
 Behavioral Health Services Manual for Community Mental Health Centers
 April 2022

7. Mobile Crisis Services	27-28
8. Therapeutic Rehabilitation Services	28
9. Psychological Testing	28
10. Screening	29
11. Assessment	29
12. Partial Hospitalization	29-30
13. Service Planning	30
14. Screening, Brief Intervention, and Referral to Treatment (SBIRT)	30-31
15. Assertive Community Treatment (ACT)	31-32
16. Intensive Outpatient Program Services (IOP)	32-34
17. Residential Services for Substance Use Disorders	34-36
18. Inpatient services under a Chemical Dependency Treatment Center (CDTC) License	36-37
19. Residential Crisis Stabilization Services	37-40
20. Day Treatment	40
21. Peer Support Services	41-42
22. Comprehensive Community Support Services	42
23. Prevention Education Services for Substance Use Risk Factors and Pregnant and/or Postpartum Case Management	42-46
24. Case Management Services for pregnant Individuals or individuals not greater than 6 months postpartum with a substance use disorder.	46-47
25. Withdrawal Management	47-48
26. Medicated Assisted Treatment (MAT)	48-49
27. Narcotic Treatment Program (NTP)	49-50
28. Applied Behavior Analysis (ABA)	50
29. Laboratory Services	51
 V. LIMITATIONS AND NON-COVERED SERVICES	 51-54
 VI. MISCELLANEOUS CLAIMS	 54-55
A. Accident and Work related Claims	54-55
B. Claims Over Twelve Months Old	55
 Appendix A – Authorized Practitioners	 55-60
Appendix B – MHA Application	61-62

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

I. INTRODUCTION

The Kentucky Medicaid Program Behavioral Health Services Manual for Community Mental Health Centers (CMHC) is intended to provide individuals associated with CMHCs with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid program. In addition, the manual is designed to facilitate the processing of claims for services provided to qualified recipients of Medicaid.

Precise adherence to policy is imperative. In order for claims to be processed quickly and efficiently, it is important to follow the policies as described in this manual. Any questions concerning general agency policy may be directed to the Cabinet for Health and Family Services, Department for Medicaid Services, Office of the Commissioner, 275 East Main Street, Mailstop 6W-A, Frankfort, Kentucky 40621, or phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services may be directed to the Cabinet for Health and Family Services, Department for Medicaid Services, Division of Policy & Operations, 275 East Main Street, Mailstop 6W-D, Frankfort, Kentucky 40621, or phone (502) 564-6890. Please refer to the billing instructions for questions concerning billing procedures or the specific status of claims.

Federal Approval and Federal Financial Participation.

The department's coverage of services pursuant to 907 KAR 1:044 (including this manual – the Behavioral Health Services Manual for CMHCs) shall be contingent upon:

1. Receipt of federal financial participation for the coverage; and
2. Centers for Medicare and Medicaid Services' approval for the coverage.

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program is administered by the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS). The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services. Title XIX is a joint federal and State assistance program

As a provider of medical services, it is important for you to be aware that DMS is bound by both federal and state statutes and regulations governing the administration of the state plan. DMS shall not reimburse for any services not covered by the state plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered or unallowable medical services.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual.

B. Advisory Council

The Kentucky Medicaid Program is guided in policy making decisions by the Advisory Council for Medical Assistance.

In accordance with the statutes, the advisory council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the advisory council, the statutes establish technical advisory committees for certain provider groups and recipients. Recipient membership on the technical advisory committees is decided by the professional organization the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the advisory council.

As necessary, the advisory council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the council.

C. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible program recipients.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

Pursuant to 907 KAR 1:005, Medicaid is the payer of last resort. Accordingly, the provider of service shall seek reimbursement from third party groups for medical services rendered. If you, as the provider, receive payment from Medicaid for a service provided to a recipient before learning that the recipient had third party liability (other insurance for example), you shall refund the Medicaid program the amount of liability owed by the third party.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

1. All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.
2. Providers shall comply with the Americans with Disabilities Act, 42 U.S.C. Sec. 12101, et seq., and any amendments, rules and regulations to this federal law.
3. Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he or she wishes to receive his or her medical care.
4. When the department or a managed care organization makes payment for a covered service and the provider accepts the payment made by the department in accordance with the department's fee structure or managed care organization in accordance with the managed care organization's fee structure, the amount paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid; however, the provider shall make the recipient aware of the non-covered services and the recipient's liability prior to rendering a non-covered service.
5. Providers of medical services attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.
6. All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky. All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

D. Public Law 92-603

Section 1909

III. CONDITIONS OF PARTICIPATION

A. Provider

1.a. As defined in 902 KAR 20:091 “A Community Mental Health Center (CMHC) shall provide a comprehensive range of accessible and coordinated behavioral health (mental health and substance use disorder services), including direct or indirect mental health services to the population of a designated regional service area as required by KRS 210.370 to 210.480.”.

b. Meet the criteria of 42 U.S.C. 300x-2(c).

c. A CMHC may provide services outside of its designated regional service area if otherwise permitted by law. Any services external to the designated regional service area shall be in compliance with relevant statutes or administrative regulations for the behavioral health service.

d. KRS 210.410 authorizes CMHCs to provide primary care services.

2. In order to be eligible to participate in the Medicaid Program, a Kentucky CMHC shall be licensed in accordance with the requirements set forth at 902 KAR 20:091.

3. Out-of-state providers shall:

a. Be appropriately licensed to provide community mental health services by the state in which they are located;

b. Participate with their state’s Title XIX Medicaid Program; and

c. Meet the Medicaid Program conditions of participation.

B. Staff. A CHMC shall:

1. Meet the staffing requirements established in 902 KAR 20:091.

2. Have a program director who shall meet the program director requirements established in 902 KAR 20:091.

3. Have a psychiatrist who:

a. Is a board certified or board eligible psychiatrist;

b. May be the clinical director;

c. Directly supervises and coordinates all planning functions in the continual development and improvement of the several service elements; and

d. Provides psychiatric services as indicated in all patient diagnosis and treatment.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

4. Utilize the following practitioners or staff who are authorized to provide services or perform duties in a CMHC:

a. A licensed psychologist who currently possesses a licensed psychologist license in accordance with KRS 319.010(6).

b.(1) A psychiatric nurse who shall be a registered nurse, licensed in the state of Kentucky with one of the following combinations of education and experience:

(i) Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.

(ii) Bachelor of Science in Nursing and one year of experience in a mental health setting.

(iii) A graduate of a three-year educational program with two years of experience in a mental health setting.

(iv) A graduate of a two-year educational program (Associate degree) with three years of experience in a mental health setting.

(2) A psychiatric nurse, only for behavioral health services, shall plan and supervise nursing services for psychiatric recipient care, and coordinate and supervise services rendered by nursing personnel with those rendered by other team administration, other departments, and medical staff in formulating policies for psychiatric patient care.

5. If a CMHC provides primary care services as permitted pursuant to KRS 210.410, the medical director for the medical primary care services delivered may be a physician, APRN, or physician assistant.

6. A medical records librarian or person capable of performing the duties of a medical records librarian shall be responsible for ongoing positive controls, for continuity of recipient care and the recipient traffic flow; assure that records are maintained, completed and preserved, and that required indexes and registers are maintained and statistical reports prepared; shall be responsible for seeing that information on recipients is immediately retrievable, for the establishment of a central records index, and for all elements of service to provide a constant check on continuity of care.

In the event that the designated individual is not a qualified medical records librarian, consultation and technical guidance shall be readily available from a person skilled in health record systems.

7. An approved behavioral health practitioner means an individual behavioral health practitioner who is independently licensed by the respective board in the Commonwealth of Kentucky who is:

a. A physician;

b. A psychiatrist;

c. An advanced practice registered nurse (APRN);

d. A physician assistant (PA);

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- e. A psychiatric resident;
- f. A resident physician;
- g. A licensed psychologist;
- h. A licensed psychological practitioner;
- i. A certified psychologist with autonomous functioning;
- j. A licensed clinical social worker;
- k. A licensed professional clinical counselor;
- l. A licensed marriage and family therapist;
- m. A licensed professional art therapist;
- n. A licensed clinical alcohol and drug counselor; or
- o. A licensed behavior analyst.

7. An approved behavioral health practitioner under supervision means an individual under the billing supervision of an approved behavioral health practitioner who is:

- a. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;
- b. A certified psychologist working under the supervision of a board-approved licensed psychologist;
- c. A marriage and family therapy associate;
- d. A certified social worker;
- e. A licensed professional counselor associate;
- f. A licensed professional art therapist associate;
- g. A licensed clinical alcohol and drug counselor associate;
- h. A certified alcohol and drug counselor; or
- i. A licensed behavioral analyst associate.

8. A professional equivalent (PE) is an individual who has approval by DMS as a professional equivalent and employed by the CMHC prior to January 1, 2018, to provide behavioral health services under the billing supervision of an approved behavioral health practitioner.

9. Mental Health Associate:

a. A Mental Health Associate (MHA) is an individual who has obtained a Bachelor's degree (BA or BS) in a human services field matriculating towards a Master's Degree in a Human Services Field. The MHA status will be designated by an application process with the Department for Medicaid Services (DMS) and granted the status of Mental Health Associate for a maximum of three (3) years from the date of approval by DMS. The Mental Health Associate must be under the direct supervision of an Approved Behavioral Health Practitioner.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

b. Each Community Mental Health Center (CMHC) shall submit to DMS an application, individual transcript from the proposed MHA undergraduate college/university, copies of any license for undergraduate degree. These documents may be emailed to DMS.ISSUES@ky.gov with Mental Health Associate Application in the subject line. Additionally, please provide a cover letter requesting consideration for a Mental Health Associate designation, return address and email. Upon decision, DMS will send the approval letter to you and your agency and notify you by email with fourteen (14) business days from the receipt of a complete application. The letter of approval must be kept in the employees agency personnel file. The MHA application is located in Appendix B of this manual.

c. A mental health associate shall not provide services to an individual with an intellectual disability without an established mental health diagnosis.

d. A mental health associate shall be limited to three (3) years of service, from the date of approval from DMS, working as a MHA in a CMHC.

e. Under certain circumstances, A CMHC can request a one (1) time extension of one (1) year for a MHA status due to not finishing their degree. To request the extension, a CMHC must email the request to DMS.ISSUES@ky.gov with MHA Extension Request in the subject line within sixty (60) days of expiration. A current transcript along with a written letter, to request the extension, must include specific reasons why the MHA status may be extended.

f. A MHA working in a CMHC as a MHA prior to January 1, 2024 shall comply with this subsection's requirements in 9.a., 9.d., and 9.e. above relating to a three (3) year limitation of practice as a MHA with a possible one (1) time extension starting two (2) years after the effective date of the ordinary administrative regulation filed with this Behavioral Health Manual for CMHCs.

10. A physician is defined by KRS 205.510(12).

11. A licensed marriage and family therapist is defined by KRS 335.300(2).

12. A marriage and family therapy associate is defined by KRS 335.300(3) and who may provide services as stated in the covered services section of this manual (Section IV) but only under the billing supervision of an Approved Behavioral Health Practitioner.

13. A licensed professional clinical counselor is defined by KRS 335.500(4).

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

14. A licensed professional counselor associate is defined by KRS 335.500(4) and who may provide covered services under the periodic direct billing supervision of an Approved Behavioral Health Practitioner.

15. An advanced practice registered nurse is defined by KRS 314.011(7).

16. A psychiatric resident physician is an individual who may provide covered services in accordance with KRS 311.571 if the resident is a medical resident as defined in 907 KAR 3:005(23).

17. A licensed clinical social worker means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

18. A certified social worker means an individual who meets the requirements established in KRS 335.080 and who may provide services as stated in the covered services section of this manual (Section IV) but only under the billing supervision of an Approved Behavioral Health Practitioner.

19. A licensed psychological practitioner means an individual who meets the requirements established in KRS 319.053.

20. A licensed psychological associate means an individual who meets the requirements established in KRS 319.064 and who may provide services as stated in the covered services section of this manual (Section IV) but only under the supervision of a board-approved licensed psychologist.

21. A certified psychologist means an individual who is a certified psychologist pursuant to KRS 319.056 and who may provide services as stated in the covered services section of this manual (Section IV) but only under the supervision of a board-approved licensed psychologist.

22. A certified psychologist with autonomous functioning means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.

23. A physician assistant is defined by KRS 311.840(3) and may provide services in the covered services section of this manual (Section IV) within the scope of their licensure.

24. A licensed professional art therapist is defined by KRS 309.130(2).

25. A licensed professional art therapist associate is defined by KRS 309.130(3) and who may provide services as stated in the covered services section of this manual

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

(Section IV) within the scope of their licensure, under the billing supervision of an Approved Behavioral Health Practitioner.

26. A licensed behavior analyst is defined by KRS 319C.010 (6).

27. A licensed assistant behavior analyst is defined by KRS 319C.010 (7) and who may provide services as stated in the covered services section of this manual (Section IV) within the scope of their licensure, under the billing supervision of an Approved Behavioral Health Practitioner.

28. A licensed clinical alcohol and drug counselor is defined by KRS 309.080(8).

29. A licensed clinical alcohol and drug counselor associate is defined by KRS 309.080(9) and who may provide services as state in the covered services section of this manual (Section IV) and within the scope of their licensure under the billing supervision of an Approved Behavioral Health Practitioner.

30. A certified alcohol and drug counselor is defined by KRS 309.080(4) and who may provide services as state in the covered services section of this manual (Section IV) and within the scope of their licensure, under the billing supervision of one of an Approved Behavioral Health Practitioner.

31. A community support associate means a paraprofessional who meets the application, training and supervision requirements of 908 KAR 2:250, and who is working under the supervision of an Approved Behavioral Health Practitioner and currently employed by the CMHC.

32. A peer support specialist is a paraprofessional who:

- a. (i) Meets the qualifications in 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240;
- (ii) Pursuant to KRS 309.0831, has completed required training,
- (iii) Is working under the supervision of an Approved Behavioral Health Practitioner; and
- (iv) Is currently employed by the CMHC.

b. As appropriate,

- (i) Has been trained and certified in accordance with 908 KAR 2:220;
- (ii) Is experiencing or has experienced a mental health disorder, substance use disorder, or co-occurring disorder; and
- (iii) Provides support services to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring disorder in order to bring about a desired social or personal change;

c. As appropriate,

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- (i) Has been trained and certified in accordance with 908 KAR 2:230;
- (ii) Is a parent or other family member of a child having or who has had a mental health, substance use, or co-occurring disorder; and
- (iii) Provides support services to a parent or family member of a child sharing a similar mental health, substance use, or co-occurring disorder in order to bring about a desired social or personal change; or

d. As appropriate;

- (i) Has been trained and certified in accordance with 908 KAR 2:240; and
- (ii) Is an individual who is identified as experiencing as a child or youth an emotional, social or behavioral disorder that is defined in the current version of the Diagnostic and Statistical Manual for Mental Disorders; or

e. As appropriate,

- (i) Is a Registered Alcohol and Drug Peer Support Specialist who has been trained and certified in accordance with KRS 309.0831;
- (ii) Is a self-identified consumer of substance use disorder services; and
- (iii) Who provides emotional support to others with substance use disorders to achieve a desired social or personal change;

33. A Registered Behavior Technician (RBT) is a paraprofessional who meets the following requirements provided by the Behavior Analyst Certification Board:

- a. Be at least eighteen (18) years of age;
- b. Have a high school diploma or its equivalent;
- c. Within (6) months of hire for a new employee or within (6) months of the effective date of this Behavioral Health Services Manual for an existing employee: 1. Complete a training program that is approved by the Behavior Analyst Certification Board, based on the current edition of the RBT Task List endorsed by the Behavior Analyst Certification Board and conducted by Behavior Analyst Certification Board certificants. 2. Pass the Registered Behavior Technician competency assessment administered by a Behavior Analyst Certification Board certificant or by an assistant assessor overseen by a Behavior Analyst Certification Board certificant. 3. Pass the Registered Behavior Technician exam provided by the Behavior Analyst Certification Board; and
- d. Is under the supervision of an appropriate practitioner.

34.a. A prevention specialist is an individual who may provide:

- (i) Pregnant or postpartum substance use prevention services as stated in Section IV (22) of this manual; and
- (ii) Pregnant or postpartum individuals case management services as stated in Section IV (22) of this manual and as listed in Appendix A;

b. A prevention specialist shall be a qualified service provider of a CMHC; and be a:

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- (i) Certified Prevention Specialist;
- (ii) Prevention specialist with a bachelor's degree or greater from an accredited college or university;
- (iii) Pregnant or postpartum case manager as indicated in Section IV (22) of this manual and as listed in Appendix A; and

c. A prevention specialist shall successfully complete any department required prevention training within six (6) months of employment as a prevention specialist including specialized training on pregnancy and substance use disorders

35. A pregnant or postpartum case manager is an individual who is a:

- a. Prevention specialist; or
- b. Pregnant or postpartum case manager with a bachelor's degree or greater from an accredited college or university; and
- c. Shall complete mandatory training as required by DBHDID and certification/licensing boards; and
- d. Successfully complete a department approved case management training within six (6) months of employment as a case manager including specialized training on pregnancy and substance use disorders.

C. Billing Supervision.

1. A billing supervisor is an Approved Behavioral Health Practitioner and defined as an individual who is:

- a. A physician;
- b. A psychiatrist;
- c. An advanced practice registered nurse (APRN);
- d. A physician assistant (PA);
- e. A psychiatric resident;
- f. A resident physician;
- g. A licensed psychologist;
- h. A licensed psychological practitioner;
- i. A certified psychologist with autonomous functioning;
- j. A licensed clinical social worker;
- k. A licensed professional clinical counselor;
- l. A licensed marriage and family therapist;
- m. A licensed professional art therapist;
- n. A licensed clinical alcohol and drug counselor; or
- o. A licensed behavior analyst.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

2. Employed by or under contract with the same community mental health center as the behavioral health practitioner under supervision who renders services under the supervision of the billing supervisor. The arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate nor substitute for the clinical supervision rules or policies of the respective professional licensure board governing the behavioral health practitioner under supervision.

3. The service note by any practitioner working under billing supervision shall be co-signed by the billing supervisor within thirty (30) days.

4. There shall be a monthly supervisory note recorded by the billing supervisor reflecting consultation concerning the case and the evaluation of services being provided to the recipient.

5. The provisions of paragraphs 3. And 4 of this section relating to service notes and monthly supervisory notes shall become effective two years after the effective date of the ordinary administrative regulation filed with this Behavioral Health Manual for CMHCs or July 1, 2024, whichever is later.

D. Affiliation Agreements. If a CMHC has agreements with other agencies or organizations to provide covered services, these agreements or contracts shall be written and shall include the following:

1. A statement specifying that the resource providing services is in compliance with all existing federal, state, and local laws and regulations governing it.

2. A statement of compliance with the Kentucky Civil Rights Act of 1977, KRS Chapter 344 and with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90, which is as follows:

“No person in the United States shall, on the ground of race, color, national origin, sex, handicap or age be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

3. A statement indicating reasonable assurance that medical services shall be provided by the health resource, when the service is deemed necessary by the recipient’s attending physician.

4. A statement indicating that at the time of transfer, or, in case of emergency, as promptly as possible after the transfer an abstract or copies of pertinent clinical and other information necessary to continue the recipient’s treatment without interruption

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

shall be sent to the facility to which the recipient transfers. The information shall include the following: current medical, mental status and physical findings; diagnosis; brief summary of the course of treatment followed, pertinent social and psychological information; nursing, medication and dietary information useful in the care of the patient; rehabilitation potential, and pertinent information concerning achievements in rehabilitation.

5. A statement indicating the effective date of the agreement that recipients may be transferred from one element of service to another without delay when appropriate for their treatment.

6. A statement indicating that the staff treating a recipient may continue to provide appropriate services during care in other elements of service, when indicated.

7. A statement indicating the basis of reimbursement between the health resource and the center.

8. A statement indicating the conditions by which the agreement may be terminated by either party.

9. Signatures by individuals authorized to execute the agreements on behalf of the resources involved.

E. Health Records

Health records regarding behavioral health services stress the psychiatric components of the record including history of findings and treatment rendered for the psychiatric condition and shall be evidence of the direct services rendered to individuals by the CMHC.

A health record shall be maintained for each individual with all entries kept current, dated, entitled according to the service received and signed by the staff recipients rendering services. Its purpose is to serve as a basis for planning treatment and training for those being served and to provide a means of communicating between all recipients of the center and its affiliated facilities.

The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to CHFS upon request and made available for inspection and copying CHFS personnel.

The specific format used for health records is left to the management of the CMHC. It is important, however, that essential information be organized in such a way as to be

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

readily accessible and adequate for the purpose of establishing the current treatment modality and progress of the individual.

Health records maintained on each recipient receiving services shall contain at least an identification sheet, permission for treatment sheet, the purpose for seeking service, problems, screening information relative to the problem, pertinent medical, psychiatric and social information disposition (result or plan of care), assigned status, assigned therapist(s) and staff service notes. The essential parts of the health record include:

1. IDENTIFICATION

The IDENTIFICATION or INTAKE SHEET shall include: name, social security number, date of intake, home (legal) address, sex, birth date, religion, next of kin or other responsible party and address, health insurance, referral source and address, personal physician and address, the reason the person is seeking help (presenting problem or diagnosis), the name of the informant and any other information needed to meet state and other center requirements.

2. SCREENING, EVALUATIONS, and DISPOSITION

The extent and type of evaluations obtained at the time of screening are dependent on the problem of the recipient seeking or being referred for service.

Screening shall include information relative to the recipient's presenting problem(s) and other personal and health needs. Screening includes determination regarding if further assessment is needed, any areas of elevated concern, and identifying individuals who may be elevated risk for suicide or violence. Psychiatric, psychological, psycho-social and other evaluations rendered following screening shall be completed in accordance with accepted professional principles.

Immediately following a screening, a disposition shall be made which documents:

- a. The status assigned to the recipient;
- b. Whether the case was referred to other staff for further discussion and, if so, to whom it was referred and what was the outcome;
- c. Whether the case was terminated and referred to an outside source for further service; or
- d. Whether the case was terminated and further service was not required.

3. STAFFING AND PLAN OF CARE REGARDING INDIVIDUALS RECEIVING BEHAVIORAL HEALTH SERVICES or BOTH BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

There shall be staffing conferences following screening to discuss cases, establish diagnosis or clinical impression, recommend additional evaluations and formulate a comprehensive plan of care which shall include short term and long range goals as well as treatment modalities. Each recipient receiving direct treatment under the auspices of a community mental health center shall have an individual plan of care signed by a clinically licensed or certified professional authorized to provide services in accordance with this manual – the Community Mental Health Center Behavioral Health Services Manual. Subsequent updates and revisions to the plan of care will be signed and updated by the clinician providing the behavioral health service. If a psychiatrist, physician (MD), or an Advanced Practice Registered Nurse (APRN) is involved in providing care to the patient, the psychiatrist, MD or APRN will also sign the plan of care. Other cases shall be discussed at staff conferences or with another professional staff during treatment of individuals for the purpose of reviewing and revising the plan of care. There shall be evidence of these conferences or consultations in the health records.

a. A plan of care shall:

- (i) Describe the services to be provided to the recipient, including the frequency of services;
- (ii) Contain measurable goals for the recipient to achieve, including the expected date of achievement for each goal;
- (iii) Describe the recipient's functional abilities and limitations, or diagnosis listed in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders™;
- (iv) Specify each staff member assigned to work with the recipient;
- (v) Identify methods of involving the recipient's family or significant others if indicated;
- (vi) Specify criteria to be met for termination of treatment;
- (vii) Include any referrals necessary for services not provided directly by the community mental health center; and
- (viii) The date scheduled for review of the plan.
- (ix) The recipient shall participate to the maximum extent feasible in the development of his or her plan of care and the participation shall be documented in the recipient's record.

b. The initial plan of care shall be developed through multidisciplinary team conferences as clinically indicated and at least thirty (30) days following the first ten (10) days of treatment.

c. The plan of care for an individual receiving residential services for a substance use

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

disorder shall be reviewed in accordance with the ASAM Criteria and according to the residential level of care;

d. The plan of care for an individual receiving partial hospitalization (PH) or intensive outpatient program (IOP) shall be reviewed every thirty (30) days.

e. The plan of care for an individual receiving all other services shall be reviewed quarterly or as medically necessary.

f. A plan of care and each review and update shall be signed by the participants, with name, title and date, in the multidisciplinary team conference that developed it.

g. A plan of care review shall be documented in the recipient's health record.

4. HISTORY and EXAMINATIONS

A complete history, including mental status and treatment rendered shall be required on all Medicaid recipients admitted for treatment by the CMHC.

A current hospital discharge summary containing history information is acceptable or if a history is done outside the center and submitted, it shall be acceptable to the psychiatrist in charge based on content.

5. SERVICE NOTES

Service notes shall be written within forty-eight (48) hours of each visit and shall describe the recipient's symptoms or behavior, reaction to treatment, attitude, the therapist's intervention, changes in plan of care, and need for continued treatment and state whether the service was provided face-to-face or by telehealth.

Edits to the notes shall clearly display the changes and be initialed and dated by the person who edited the notes. Notes shall not be erased or illegibly marked out.

All service notes shall be in chronological order, dated, entitled as to service rendered, have a starting and ending time for the services, and be recorded and signed by the staff person rendering the service with title (i.e., LCSW, Psych., LCADC, etc.). The service note shall include the specific service rendered, the setting of the service, the relationship of the service to the treatment goals and objectives in the plan of care, and the individual's progress toward the treatment goals and objectives. Family collateral, telephone and other significant contacts or collateral information shall also be recorded in the staff notes.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

All service notes shall be recorded and signed by the staff person rendering the service. Initials, typed or stamped signatures are not acceptable.

For therapeutic rehabilitation services, the service notes of the person delivering the service may be recorded daily, or if the CMHC prefers, as a weekly summary as long as the attendance worksheets are maintained. The weekly summary service notes shall include a description of the recipient's symptoms or behavior, reaction to treatment, demeanor, changes in plan of care, and need for continued treatment. In addition, a description of activities and how the activities were used to facilitate psychiatric therapy shall also be included in the service note.

6. MEDICATION

All medication prescribing and monitoring used in treatment shall be recorded in service notes. Except as otherwise provided in KRS 217, 218A, or Title 907 KAR.

A CMHC with the capacity to use electronic prescribing may do so and shall be able to produce a hard copy of each prescription.

If a CMHC does not use electronic prescribing, the CMHC shall document each prescription on a form designated specifically for medications for easy reference and follow-up and keep a copy of each prescription issued in the health record of each recipient for whom a prescription was issued.

Prescriptions shall not exceed an order for more than five (5) refills.

7. DIAGNOSIS or CLINICAL IMPRESSION

A diagnosis or clinical impression shall be in the terminology of the most current edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*TM.

Other co-occurring (physical) diagnoses shall be recorded, followed by information as to where treatment is being received and by whom it is being provided.

Diagnoses shall be recorded in the health record within three (3) visits, in order to receive Medicaid payment except when the visit is for any of the following services:

- a. Mobile crisis services;
- b. Crisis intervention;
- c. A screening;
- d. An assessment;

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- e. A screening, brief intervention, and referral to treatment for a substance use disorder (SBIRT); or
- f. Peer support services for the engagement into substance use treatment within ED Bridge Clinics;

8. DISCHARGE SUMMARY

A discharge summary is required on all recipients seen in excess of three (3) behavioral health visits and shall contain a recapitulation of the significant findings and events during treatment, including the final evaluation regarding progress of the recipient toward goals and objectives set forth in the plan of care, final diagnosis of clinical impression, and condition on termination and disposition.

9. HEALTH RECORD COMPLETION

Evaluations and examinations are to be completed within three (3) working days following visits, unless an earlier completion time is required pursuant to other law or by a professional standard or criteria, including the ASAM Criteria.

Health records of discharged cases are completed within ten (10) days following discharge.

If a case is reopened within ninety (90) days for the same or related problem, reference to the previous case history, an interval note shall suffice for an intake and an assessment.

10. RETENTION OF RECORDS

All health records of discharged recipients shall be completed promptly and retained as established in 907 KAR 1:044.

In the event of a change in management of a CMHC program, all health records, indexes and registers shall remain the property of the center and be transferred to the new owner.

If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for care or treatment, the transferring CMHC shall, within forty eight (48) hours of the transfer or referral, transfer the recipient's records in a manner that complies with the records' use and disclosure requirements as established in or required by: The Health Insurance Portability and Accountability Act; 42 U.S.C. 1320d-2 to 1320d-8; and 45 C.F.R. Parts 160 and 164; or 42 C.F.R Part 2.

11. CONFIDENTIALITY OF HEALTH RECORDS

All information contained in the health record is treated as confidential and is disclosed only to authorized persons, authorized CHFS representatives, authorized managed care organization representatives, or authorized representation of the federal government. The provider shall provide to representatives of CHFS or a managed care organization in which a recipient is enrolled requested information to substantiate:

- a. Service notes detailing service rendered
- b. Professional rendering service
- c. Type of service rendered and any other requested information necessary to determine on an individual recipient and service basis whether services are reimbursable by Medicaid.

Failure of the CMHC to provide to CHFS staff, or managed care organization staff if the recipient is enrolled with a managed care organization, requested documentation shall result in denial of payment for those billed services.

F. Application for Participation

A CMHC, being in compliance with the standards as outlined in Title II of Public Law 88-164, licensed in accordance with 902 KAR 20:091 and meeting the requirements of Medicaid as set forth in 907 KAR 1:044, shall submit a Provider Application, through KY Medicaid Partner Portal Application (KY MPPA).

G. Out-of-State Facility

Kentucky Medicaid reimbursement for outpatient psychiatric services provided in an out-of-state facility is limited to the following conditions as specified in 42 CFR 431.52:

“A State Plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:

1. Medical services are needed because of a medical emergency;
2. Medical services are needed and the beneficiary’s health would be endangered if he were required to travel to his state of residence;
3. The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

4. It is general practice for beneficiaries in a particular locality to use medical resources in another state;

The out-of-state facility shall be licensed to provide the community mental health center or outpatient psychiatric services by the state in which it is located, and shall participate as a provider of these services in that state's title XIX (Medicaid) Program.

An out-of-state facility shall submit a copy of the negotiated participation agreement with their state's Title XIX Program and a copy of that state's Medicaid reimbursement rates for the covered services, in addition to the items listed in paragraph G. Application for Participation, this section

H. Termination of Participation

1. 907 KAR 1:671 regulates the terms and conditions of provider participation and procedures for provider appeals. CHFS determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

a. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

b. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

c. Misrepresenting factors concerning a facility's qualifications as a provider;

d. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

e. Submitting false or questionable charges to the agency.

2. The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement in accordance with 907 KAR 1:671. The notice shall state:

a. The reasons for the decision

b. The effective date

c. The extent of its applicability to participation in the Kentucky Medicaid Program

d. The earliest date on which CHFS shall accept a request for reinstatement

e. The requirements and procedures for reinstatement; and

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

f. The appeal rights available to the excluded party.

3. Pursuant to 907 KAR 1:671, the provider receiving the notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for CHFS. When an evidentiary hearing is held, the provider is entitled to the following:

- a. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
- b. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
- c. Counsel representing the provider;
- d. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
- e. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. A hearing shall follow the process outlined for provider appeals in 907 KAR 1:672 and KRS Chapter 13B, as appropriate.

These procedures apply to any provider who has received notice from CHFS of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon Medicaid. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

I. DEFINITION OF TELEHEALTH

Telehealth is defined and regulated within the Medicaid program pursuant to 907 KAR 3:170.

IV. COVERED SERVICES

Services provided by participating community mental health centers shall be covered through the community mental health center element of the Kentucky Medicaid Program when provided in accordance with this manual: the Community Mental Health Center Behavioral Health Services Manual, and 907 KAR 1:044. All covered services are listed in Appendix A of this manual.

Rehabilitative Mental Health and Substance Use Services

1. General Information

- a. Rehabilitative mental health and substance use services may be either onsite, which are defined as the CMHC, leased space and donated space, or off-site which includes the recipient's home, congregate living facility not otherwise reimbursed by Medicaid, with the exception of an Institute for Mental Disease (IMD), school or day care center, senior citizen's center, and family resource and youth center.
- b. Co-occurring disorder means a mental health diagnosis and substance use disorder.
- c. All services shall be provided in accordance with a plan of care.
- d. Ongoing consultation shall also be maintained with the supervisory staff throughout the duration of the recipient's treatment. Staff notes shall clearly reflect the input of the recipient. If a supervising professional was involved, the staff notes shall contain the supervising professional's signature.
- e. A provider shall refer to 907 KAR 3:170 to determine:
 - (i) The appropriateness of any service for telehealth; and
 - (ii) How that service may be conducted via telehealth.

2. Individual Outpatient Therapy

Individual Outpatient Therapy is a therapeutic intervention service in accordance with a recipient's identified plan of care and is aimed at the reduction of adverse symptoms and improved functioning.

3. Group Outpatient Therapy

Group Outpatient Therapy is a therapeutic intervention service that is provided to a group of unrelated persons except for multi-family group outpatient therapy. A group consists of no more than twelve (12) persons of nonrelated individuals, except of multi-family group therapy. In group therapy, recipients are involved with one another at a cognitive and emotional level.

Group therapy focuses on psychological needs of the recipients as evidenced in each recipient's plan of care. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and shall have a defined course of treatment. Individual notes shall be written for each recipient within the group and be kept in that individual's medical record.

4. Family Outpatient Therapy

Family Outpatient Therapy is a therapeutic intervention service through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.

The need for family therapy shall be so stated in the recipient's plan of care. Family therapy services shall be for the benefit of the recipient.

5. Collateral Outpatient Therapy

Collateral outpatient therapy services limited to recipients under the age of twenty-one (21), who are recipients of the rendering provider. Collateral outpatient therapy service is an encounter with a parent/caregiver, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the recipient, for the purpose of providing counseling or consultation on behalf of a recipient in accordance with an established plan of care. The parent or legal representative in a role of supervision of the recipient shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under the age of twenty-one (21) years.

Persons in a role of supervision may include day care providers, house parents, camp counselor, patient's physician, or a social worker with case management responsibility who is not employed by the CMHC.

Services delivered to more than one (1) person at the same time shall be billed as if the time were spent with an individual recipient.

A billable unit of service is the actual time spent face-to-face or via telehealth delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

6. Crisis Intervention Services

Crisis Intervention is a therapeutic intervention service provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the recipient, or others. This service shall be provided as an immediate relief to the presenting problem or threat. Crisis Intervention shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization, interventions, or crisis prevention activities for individuals. It shall be followed by non-crisis service referral as appropriate.

Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk and substance use relapse prevention.

7. Mobile Crisis Services

Mobile Crisis provides the same services as crisis intervention, except the location for the service is not in the office. Services are available twenty-four (24) hours a day, seven (7) days a week, 365 days a year. This service is provided in duration of less than twenty-four (24) hours and is not considered an overnight service but is covered any time during twenty-four (24) hours of a day. This service shall be a multi-disciplinary team based intervention provided in a home or in a community setting that ensures access to mental health and substance use disorder services and supports to reduce symptoms or harm or to safely transition persons in acute crises to the appropriate least restrictive level of care. Mobile crisis shall also involve all services and supports necessary to provide integrated crisis prevention, assessment and disposition, intervention, continuity of care recommendations, and follow-up services.

To provide mobile crisis services, a CMHC shall have:

- a. The capacity to employ required practitioners and coordinate service provision among the rendering practitioners;
- b. The capacity to provide the full range of mobile crisis services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;
- c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;
- d. The administrative capacity to ensure quality of services;

- e. A financial management system that provides documentation of services and costs; and
- f. The capacity to document and maintain individual case records.

8. Therapeutic Rehabilitation Services TREATMENT FOR MENTAL HEALTH ONLY

a. Therapeutic Rehabilitation Services is a rehabilitative service for adults with serious mental illnesses and recipients under the age of twenty-one years who have a severe emotional disability designed to maximize reduction of the symptoms associated with a mental health disorder and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills, self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

c. To provide therapeutic rehabilitation services a CMHC shall:

- (i) Have the capacity to employ staff authorized to provide therapeutic rehabilitation services in accordance with this section and to coordinate the provision of services among team members;
- (ii) Have the capacity to provide the full range of therapeutic rehabilitation services as stated in this paragraph;
- (iii) Have demonstrated experience in serving individuals with mental health disorders;
- (iv) Have the administrative capacity to ensure quality of services;
- (v) Have a financial management system that provides documentation of services and costs; and
- (vi) Have the capacity to document and maintain individual case records.

9. Psychological Testing

a. Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psychodiagnostic assessment of personality, psychopathology, emotionality, and/or intellectual abilities. This also includes interpretation and written report of testing results.

b. Psychological testing shall be performed by an individual who has met the requirements of KRS Chapter 319 related to the necessary credentials to perform psychological testing.

10. Screening

Screening shall be the determination of the likelihood that a person has a mental health, substance use, or co-occurring disorders. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment.

11. Assessment

a. An assessment shall include gathering information and engaging in a process with the recipient that enables the provider to establish the presence or absence of a mental health or substance use disorder, determine the recipient's readiness for change, identify recipient strengths or problem areas that may affect the processes of treatment and recovery, and engage the recipient in the development of an appropriate treatment relationship. The purpose of an assessment is to establish, or rule out, the existence of a clinical disorder or service need and to work with the recipient to develop a treatment and service plan. This does not include psychological or psychiatric evaluations or assessments.

b. The extent and type of assessment performed shall depend upon the problem of the individual seeking or being referred for services.

c. If an assessment is being provided for the treatment of a substance use disorder, utilize a multidimensional assessment that complies with the most current edition of *The ASAM Criteria* in order to determine the most appropriate level of care.

12. Partial Hospitalization

a. Partial Hospitalization (PHP) is a short-term (average of four (4) to six (6) weeks) service of less than twenty-four (24)-hour each day.

b. PHP is a treatment program for an individual who is experiencing significant impairment to daily functioning due to substance use, mental health, or co-occurring disorders.

c. Partial Hospitalization may be provided to adults or a minor.

d. Admission criteria for PHP shall be based on the inability of community-based therapies or intensive outpatient services to adequately treat the recipient.

e. A PHP shall meet the service criteria, including the components for support systems, staffing and therapies outlined in the most current edition of *The ASAM Criteria* for PHP level of care services if treatment is for SUD.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

f. A PHP program shall consist of:

- (i) Individual outpatient therapy;
- (ii) Group outpatient therapy;
- (iii) Family outpatient therapy; or
- (iv) Medication management.

g. The department shall not reimburse for educational, vocational or job training services provided as part of partial hospitalization.

h. A CMHC's PHP shall have an agreement with the local educational authority to come into the program to provide all educational components and instruction that are not Medicaid billable or reimbursable. Services in a Medicaid eligible child's individualized education program (IEP) shall be coverable under Medicaid.

i. Partial hospitalization shall be provided for at least (4) four hours per day and focused on (1) one primary presenting problem.

j. The PHP shall include the following personnel:

- (i) For the purpose of providing medical care available on site: an advanced practice registered nurse, a physician assistant, or a physician; and
- (ii) Available for consultation: a board certified or board eligible psychiatrist.

k. A CMHC shall have the capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles.

l. A CHMC shall employ required practitioners and coordinate service provisions in order to provide the full range of services included in the scope of partial hospitalization.

13. Service Planning

Service planning is a service that involves assisting the recipient in creating an individualized plan for services needed for maximum reduction of the effects of a mental health disorder and restoration of a recipient to the recipient's best possible functional level. A person centered planning process is required. The plan is directed by the recipient and shall include practitioners of the recipient's choosing. The providers include more than licensed professionals; it may include the recipient (and the recipient's guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses.

14. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- a. SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.
- b. SBIRT consists of three major components:
 - (i) Screening: Assessing an individual for risky substance use behaviors using standardized screening tools;
 - (ii) Brief Intervention: Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and
 - (iii) Referral to Treatment: Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus to a behavioral health service.
- c. A screening and brief intervention that does not meet criteria for referral to treatment is subject to coverage by the department.

15. Assertive Community Treatment, TREATMENT FOR MENTAL HEALTH ONLY

- a. Assertive community treatment (ACT) shall be an evidence-based psychiatric rehabilitation practice that provides a comprehensive approach to service delivery for individuals with a serious mental illness.
- b. ACT services include:
 - (i) Assessment;
 - (ii) Treatment planning;
 - (iii) Case management;
 - (iv) Individual outpatient therapy;
 - (v) Family outpatient therapy;
 - (vi) Group outpatient therapy;
 - (vii) Mobile crisis services;
 - (viii) Crisis intervention;
 - (ix) Mental health consultation; or
 - (x) Family support and basic living skills.
- c. Mental health consultation shall involve brief, collateral interactions with other treating professionals who may have information for the purpose of treatment planning and service delivery.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

d. Family support shall involve the assertive community treatment team's working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase the recipient's autonomy and independent functioning.

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

f. To provide assertive community treatment services, a community mental health center shall employ One (1) or more teams led by an approved behavioral health services provider and including at a minimum, 1.0 FTE therapist, 1.0 case manager, .5 peer support specialist, .5 FTE nurse and 1.0 FTE of the team's choosing with access to a prescriber.

g. Adequate staffing to assure a caseload size no greater than ten (10) participants per team member (for example, if the team includes five (5) individuals, the caseload for the team shall not exceed fifty (50) recipients).

h. CMHCs shall have the capacity to:

(i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph.

(ii) Coordinate the provision of services among team members.

(iii) Provide the full range of assertive community treatment services as stated in this paragraph.

(iv) Document and maintain individual case records.

(v) Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.

16. Intensive Outpatient Program Services

a. Intensive outpatient program (IOP) services shall:

(i) Be an alternative to or transition from inpatient hospitalization, residential treatment or partial hospitalization for mental health, substance use, or co-occurring disorders.

(ii) Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual, group or family outpatient therapy; and

(iii) Be provided at least three (3) hours per day at least three (3) days per week. If IOP is being provided for SUD treatment it must meet the service criteria for this level of care using the current edition of *The American Society of Addiction Medicine's (ASAM) Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

b. Include:

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

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

unless contraindicated;

- (ii) Crisis intervention;
- (iii) Psycho-education; and
- (iv) Care coordination.

c. During psycho-education the recipient or family member shall be:

- (i) Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and
- (ii) Taught how to cope with the recipient's diagnosis or condition in a successful manner.

d. An intensive outpatient program shall establish a plan of care for each recipient receiving services from an intensive outpatient program which shall meet the treatment plan requirements established in 902 KAR 20:160.

e. An intensive outpatient program treatment plan shall be individualized; and focus on stabilization and transition to a lesser level of care.

f. To provide intensive outpatient program services, a CMHC shall have:

- (i) Access to a board-certified or board-eligible psychiatrist for consultation;
- (ii) Access to a psychiatrist, other physician, or advanced practiced registered nurse for medication management;
- (iii) Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one (1) staff;
- (iv) The capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles;
- (v) The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members;
- (vi) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;
- (vii) Demonstrated experience in serving individuals with behavioral health disorders;
- (viii) The administrative capacity to ensure quality of services;
- (ix) A financial management system that provides documentation of services and costs;
- (x) The capacity to document and maintain individual case records.

g. These services shall be provided:

- (i) In a setting with a minimum recipient-to-staff ratio of ten (10) to one (1); and
- (ii) By behavioral health professionals who utilize a recognized intervention protocol that shall be based on recovery principles; and

- (iii) For a recipient who is not This an enrollee, be approved by the Department for Behavioral Health, Developmental and Intellectual Disabilities; or
- (iv) For a recipient, be approved by the managed care organization in which the recipient is enrolled.

17. Residential Services for Substance Use Disorders

Residential services for substance use disorders shall be provided following an assessment of an individual and a determination they meet the dimensional admission criteria for residential level of care placement in accordance with the most current edition of *The ASAM Criteria*. Residential services shall be provided in a twenty-four (24) hour per day unit that is a live in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring disorders and assist a recipient in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery and in making necessary changes in the recipient's life to enable the recipient to live drug or alcohol free. Provide intensive treatment and skills building in a structured and supportive environment.

- a. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse residential treatment program in accordance with 908 KAR 1:370 and 908 KAR 1:372.
- b. Be provided under the medical direction of a physician.
- c. Provide continuous nursing services in which a registered nurse shall be:
 - (i) On-site during traditional first shift hours, Monday through Friday;
 - (ii) Continuously available by phone after hours;
 - (iii) On-site as needed in follow up to telephone consultation after hours;
- d. Meet the service criteria including the components for support systems, staffing and therapies outlined in the most current edition of *The ASAM Criteria* for residential level of care services. Be based on individual need and may include:
 - (i) Screening;
 - (ii) Assessment;
 - (iii) Service planning;
 - (iv) Individual therapy;
 - (v) Group therapy;
 - (vi) Family therapy;
 - (vii) Peer support;
 - (viii) Clinically Managed Withdrawal Management;
 - (ix) Medication Assisted Treatment:
Medication assisted treatment shall be available per patient choice for the treatment of a substance use disorder or co-occurring disorders.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

If a residential treatment program for SUD does not offer MAT on-site, care coordination shall be provided to facilitate MAT off-site is necessary by recipient choice. If the choice in MAT is methadone, the residential provider shall establish a contractual relationship with a Narcotic Treatment Program that dispensed methadone;

(x) Care coordination:

Care coordination in substance use treatment is essential in meeting recipient's needs and treatment goals to improve overall health outcomes, and requires continued follow up, progress monitoring and tracking of patient outcomes to ensure these goals are met. For those recipients being treated for a substance use disorder, care coordination shall include at minimum;

- Referring the recipient to appropriate community services;
- Facilitating medical and behavioral health follow-ups;
- Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support; and
- Facilitating medication assisted treatment as necessary, per patient choice, if the medication is not offered on-site.

e. Residential services for a substance use disorder shall not include:

- (i) Room and board;
- (ii) Educational services;
- (iii) Vocational services;
- (iv) Job training services;
- (v) Habilitation services;
- (vi) Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;
- (vii) Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;
- (viii) Recreational activities;
- (ix) Social activities; or
- (x) Services required to be covered elsewhere in the state plan. The physical structure in which residential services for a substance use disorder are provided shall not:
 - (xi) Contain more than sixteen (16) beds unless every recipient receiving services in the building is under the age of twenty-one (21) years or over the age of sixty-five (65) years in which case the limit of sixteen (16) beds shall not apply; and
 - (xii) Be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate unless every recipient receiving services in the multiple units is under the age of twenty-one (21) years or over the age of sixty-five (65) years in which case the limit of sixteen (16) beds shall not apply.

*The limit of sixteen (16) beds shall not apply if the facility possesses a departmental provisional certification to provide residential substance use disorder services that are equivalent to the appropriate level of *The ASAM Criteria*.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

****After July 1, 2022, possess an appropriate ASAM Level of Care Certification in accordance with *The ASAM Criteria*.**

- f. To provide residential services for a substance use disorder, a CMHC shall:
- (i) Have the capacity to employ staff authorized to provide services in accordance with this section and to coordinate the provision of services among team members;
 - (ii) Have the capacity to provide the full range of residential services for a substance use disorder as stated in this paragraph;
 - (iii) Have demonstrated experience in serving individuals with behavioral health disorders;
 - (iv) Have the administrative capacity to ensure quality of services;
 - (v) Have a financial management system that provides documentation of services and costs; and
 - (vi) Have the capacity to document and maintain individual case records.

18. Inpatient services under a Chemical Dependency Treatment Center (CDTC) License

Inpatient services under a CDTC license:

- a. Are structured inpatient programs to provide medical, social, diagnostic and treatment services to individuals with a substance use disorder;
- b. Shall 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;
- c. Meets the service criteria for medically monitored intensive inpatient services and withdrawal management using the current edition of *The ASAM Criteria*;
- d. Includes the component services:
 - (i) Screening,
 - (ii) Assessment,
 - (iii) Service planning,
 - (iv) Psychiatric services,
 - (v) Individual therapy,
 - (vi) Family therapy,
 - (vii) Group therapy
 - (viii) Peer support services,
 - (ix) Medication assisted treatment:If a residential treatment program for SUD does not offer MAT on-site, care coordination shall be provided to facilitate MAT off-site is necessary by recipient choice,
- (x) Medically Monitored Withdrawal management:

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

Withdrawal management services provided in a CDTC shall meet the service criteria for medically monitored intensive inpatient withdrawal management services using the current edition of *The ASAM Criteria*; and

(xi) Care coordination:

Care coordination in substance use treatment is essential in meeting recipients' needs and treatment goals to improve overall health outcomes, and requires continued follow up, progress monitoring and tracking of patient outcomes to ensure these goals are met. Care coordination shall also include facilitating medication assisted treatment for recipients as necessary per recipient choice.

For those recipients being treated for a substance use disorder, care coordination shall include at minimum:

- Referring the recipient to appropriate community services;
- Facilitating medical and behavioral health follow-ups;
- Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support; and
- Facilitating medication assisted treatment as necessary, per patient choice, if the medication is not offered on-site.

e. Medication assisted treatment shall be available per patient choice for the treatment of a substance use disorder or co-occurring disorders.

f. If the choice in MAT is methadone, the residential provider shall establish a contractual relationship with a Narcotic Treatment Program that dispenses methadone.

g. To provide inpatient services in a CDTC for a substance use disorder, a CMHC shall have a CDTC license in accordance with 902 KAR 20:160.

**After July 1, 2022, possess an appropriate ASAM Medically Monitored Intensive Inpatient Level of Care Certification in accordance with The ASAM Criteria

19. Residential Crisis Stabilization Services

a. Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community based, residential programs that offer an array of services in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization, but need overnight care. These services are provided to stabilize a crisis and divert an individual from a higher level of care, stabilize and provide treatment for medically monitored withdrawal management and to re-integrate the individual into the community or other appropriate setting.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

b. Residential crisis stabilization services for substance use disorders shall be provided following an assessment of an individual and a determination they meet the dimensional admission criteria for residential level of care placement in accordance with the most current edition of *The ASAM Criteria*.

c. Residential services shall be provided in a twenty-four (24) hour per day unit that is a live in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring disorders.

d. Residential crisis stabilization services (Mental health, SUD or co-occurring) shall be provided in a crisis stabilization unit (RSCU).

e. A crisis stabilization unit shall be a community-based, residential program that offers an array of services including:

- (i) Screening;
- (ii) Assessment;
- (iii) Treatment planning;
- (iv) Individual outpatient therapy;
- (v) Family outpatient therapy;
- (vi) Group outpatient therapy;
- (vii) Psychiatric services;
- (viii) Peer support;
- (ix) Medically Monitored Withdrawal Management (SUD Services only);
- (x) Medication Assisted Treatment (SUD Services only); and
- (xi) Care coordination. Care coordination in substance use treatment is essential in meeting recipients' needs and treatment goals to improve overall health outcomes, and requires continued follow up, progress monitoring and tracking of patient outcomes to ensure these goals are met. For those recipients being treated for a substance use disorder, care coordination shall include at minimum:
 - Referring the recipient to appropriate community services;
 - Facilitating medical and behavioral health follow-ups;
 - Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support; and
 - Facilitating medication assisted treatment as necessary, per patient choice, if the medication is not offered on-site.

Care coordination shall also include facilitating medication assisted treatment for recipients as necessary per recipient choice.

f. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate unless every recipient receiving services in the multiple units is under the age of twenty-one (21) years or over the age of sixty-five (65) years in which case the limit shall not apply.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

**After July 1, 2022, possess a Medically Monitored Intensive Inpatient Services Level of Care Certification appropriate for an RCSU treating SUD in accordance with *The ASAM Criteria*.

g. Residential crisis stabilization shall not include:

- (i) Room and board;
- (ii) Educational services;
- (iii) Vocational services;
- (iv) Job training services;
- (v) Habilitation services;
- (vi) Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;
- (vii) Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;
- (viii) Recreational activities;
- (ix) Social activities; or
- (x) Services required to be covered elsewhere in the state plan.

h. To provide residential crisis stabilization services, a CMHC shall have:

- (i) The capacity to employ staff authorized to provide residential crisis stabilization services in accordance with this section and to coordinate the provision of services among team members;
- (ii) The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;
- (iii) Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;
- (iv) Demonstrated experience in serving individuals with behavioral health disorders;
- (v) The administrative capacity to ensure the quality of services;
- (vi) A financial management system that provides documentation of services and costs;
- (vii) The capacity to document and maintain individual case records;
- (viii) If residential crisis stabilization and withdrawal management is being provided for SUD treatment it must meet the service criteria for medically monitored level of care using the current edition of *The American Society of Addiction Medicine's (ASAM) Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. Medically monitored intensive services shall meet the criteria including the components for support systems, staffing and therapies outlined in *The ASAM Criteria* for medically monitored level of care services.
- (ix) If a residential treatment program for SUD does not offer MAT on-site, care coordination shall be provided to facilitate MAT off-site is necessary by recipient choice.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

If the choice in MAT is methadone, the residential provider shall establish a contractual relationship with a Narcotic Treatment Program that dispensed methadone.

20. Day Treatment

Day treatment shall be a non-residential, intensive treatment program for a child under the age of twenty-one (21) years who has a mental health disorder, substance use disorder, or co-occurring disorder; and a high risk of out-of-home placement due to a behavioral health issue.

a. Day treatment shall consist of an organized, behavioral health program of treatment and rehabilitative services, including:

- (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
- (ii) Behavior management and social skills training;
- (iii) Independent living skills that correlate to the age and developmental stage of the recipient; or
- (iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge.

b. Day treatment services provided are to be provided:

- (i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
- (ii) On school days and during scheduled breaks;
- (iii) In coordination with the recipient's individual educational program or Section 504 plan if the recipient has an individual educational program or Section 504 plan;
- (iv) Under the supervision of an approved behavioral health practitioner or an approved behavioral health practitioner under supervision; and
- (v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider; and via Face-to-face.

c. To provide day treatment services, a CMHC shall have:

- (i) The capacity to employ staff authorized to provide day treatment services in accordance with this section and to coordinate the provision of services among team members; and
- (ii) Knowledge of mental health, substance use or co-occurring disorders.
- (iii) The administrative capacity to ensure quality of services;
- (iv) A financial management system that provides documentation of services and costs;
- (v) The capacity to document and maintain individual case records; and shall not include a therapeutic clinical service that is included in a child's individualized education program or Section 504 plan.

21. Peer Support Services

a. Peer support services shall:

- (i) Be an evidence-based practice.
- (ii) Be structured and scheduled non-clinical therapeutic activities with an individual recipient or a group of recipients.
- (iii) Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient.
- (iv) Be coordinated within the context of a comprehensive, individualized plan of care developed through a person-centered planning process.
- (v) Be identified in each recipient's plan of care.
- (vi) Be designed to directly contribute to the recipient's individualized goals as specified in the recipient's plan of care.
- (vii) Be supervised by an Approved Behavioral Health Practitioner employed by the same CMHC as the behavioral health practitioner under supervision who renders services under the supervision of the billing supervisor.
- (viii) Except for engagement into substance use disorder treatment through an emergency department bridge clinic, be coordinated within the context of a comprehensive, individualized plan of care developed through a person-centered planning process.
- (ix) Be identified in each recipient's plan of care; and
- (x) Be designed to directly contribute to the recipient's individualized goals as specified in the recipient's plan of care.

b.(i) Individuals providing peer support services to recipients shall provide no more than thirty (30) hours per week of direct recipient contact.

(ii) Peer support services being provided to recipients in a group setting shall not exceed eight (8) individuals within any group at one (1) time.

c. Peer support specialists shall have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and shall complete the training requirements approved by (DBHDID).

d. To provide peer support services a CMHC shall:

- (i) Have demonstrated the capacity to provide peer support services for the behavioral health population being served including the age range of the population being served;
- (ii) Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220, 908 KAR 2:230, and/or 908 KAR 2:240, or KRS 309.0831;
- (iii) Have the capacity to coordinate the provision of services to supervise peer support specialists;
- (iv) Have the capacity to provide on-going continuing education and technical

assistance to peer support specialists;

(v) Have the administrative capacity to ensure quality of services;

(vi) Have a financial management system that provides documentation of services and costs; and

(vii) Have the capacity to document and maintain individual case records.

22. Comprehensive Community Support Services. TREATMENT FOR MENTAL HEALTH ONLY.

a. Comprehensive community support services shall:

(i) Be activities necessary to allow an individual to live with maximum independence in the community;

(ii) Be intended to ensure successful community living through the utilization of skills training as identified in the recipient's plan of care;

(iii) Consist of using a variety of psychiatric rehabilitation techniques to improve daily living skills, improve self-monitoring of symptoms and side effects, improve emotional regulation skills, improve crisis coping skills and develop and enhance interpersonal skills; and

(iv) Be provided under the billing supervision of an approved Behavioral Health Practitioner or an approved Behavioral Health Practitioner under supervision employed by the same CMHC. A community support associate under supervision of an approved behavioral health practitioner may provide support services under this paragraph.

b. To provide comprehensive community support services, a CMHC shall have:

(i) The capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with this section and to coordinate the provision of services among team members;

(ii) Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

(iii) The administrative capacity to ensure quality of services;

(iv) A financial management system that provides documentation of services and costs; and

(v) The capacity to document and maintain individual case records.

23. Prevention Education with substance use risk factors for Pregnant Individuals or Postpartum Individuals with a substance use disorder

a. General eligibility criteria for Substance Use Prevention Education Services for Pregnant Individuals or Individuals not greater than six (6) months postpartum:

(i) To qualify for prevention education with substance use risk factors and/or case management services for pregnant individuals or postpartum individuals with a

substance use disorder pursuant to this manual- the Behavioral Health Services Manual

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

for CMHCs- an individual shall meet Medicaid program eligibility requirements pursuant to 907 KAR 20:010 or 907 KAR 20:100;

- (ii) Not have a medical or psychiatric condition that requires immediate medical care in order for the individual to benefit from an identified service;
- (iii) Not be at high risk for harm to self or others or the level of risk can be adequately managed with the parameters of the identified service; and
- (iv) May benefit from participation in the identified prevention education service.

b. General eligibility criteria for Prevention Education, including universal, selective and indicated prevention education services, for pregnant individuals or individuals not greater than six (6) months postpartum. To qualify for a universal prevention service an individual shall:

- (i) Meet Medicaid program eligibility requirements pursuant to 907 KAR 20:010 or 907 KAR 20:100;
- (ii) Have no identified biological, psychological, or social factors which would increase risk or initiating use of alcohol or other drugs during pregnancy;
- (iii) Have no identified history if personal use of substances that has contributed to a lifestyle, legal problem, or other symptom indicating the need for a substance use prevention or treatment service;
- (iv) Not meet the criteria for an identified substance use disorder;
- (v) Be delivered as a group or one-on-one service;
- (vi) Utilize an established substance use risk reduction curriculum approved by the division;
- (vii) Be delivered as a face-to-face contact between pregnant individuals and/or individuals not greater than six (6) months postpartum and a qualified prevention specialist or case manager who meets the requirements as listed in 22.III.(E); and
- (viii) Have received a substance use screening and/or referred for a substance use assessment.

c. A selective prevention education service shall be delivered as a group or one-on-one service to pregnant individuals or individuals not greater than six (6) months postpartum by a qualified prevention specialist or case manager.

To qualify for a selective prevention education service, an individual shall;

- (i) Meet Medicaid program eligibility requirements pursuant to 907 KAR 20:010 or 907 KAR 20:100;
- (ii) Give evidence of risk of substance use as defined by identification of household members and significant others in the individual's life who use substances; family history of substance use; history of emotional, sexual, and physical abuse; or a history of mental health issue and diagnosis;
- (iii) Not have admitted to using substances during the last thirty (30) days;
- (iv) Have received a substance use screening or referral for a substance use assessment; and

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

(v) Utilize an established substance use risk reduction curriculum approved by the division.

d. To qualify for an indicated prevention education service, an individual shall;

(i) Meet the general eligibility criteria stated in 22.I (A);

(ii) Have received a substance use screening and/or referred for a substance use assessment

(iii) Have used substances since learning of their pregnancy or has exhibited problematic behaviors prior to pregnancy associated with substance use;

(iv) Have exhibited risk factors that increases their chances of developing a substance use disorder.

(v) Utilize an established substance use risk reduction curriculum approved by the division; and

(vi) Be delivered as a face-to-face contact between pregnant individuals and/or individuals not great than six (60 months postpartum and a prevention specialist or case manager who meets the requirements as listed in 22.II (E).

e. Universal prevention education services shall be conducted by a prevention specialist or a case manager and consist of an established curriculum for substance use risk reduction that shall:

(i) Reduce the risk of substance use for pregnant individuals and/or individuals not greater than six (6) months postpartum, thus protecting their current and future children from subsequent risk for harm;

(ii) Identify specific risks associated with substance use during pregnancy and lactation, including developmental risks to a fetus/baby;

(iii) Identify signs of postpartum depression and address the risks associated with substance use during the postpartum period; and

(iv) Reduce the shame and stigma associated with substance use during pregnancy and encourage a pregnant Individual and/or a postpartum individual to pursue additional substance use prevention education and treatment services as determined necessary;

(v) Include a screening process for the identification of a pregnant individual or individual not greater than six (6) months postpartum needing a referral for a selective or indicated prevention education service or a substance use disorder assessment; and

(vi) Limit reimbursement to no more than two (2) hours per calendar year for universal prevention services for pregnant individuals and/or individuals not greater than six (6) months postpartum.

f. Selective prevention education services shall be conducted by a prevention specialist or a pregnant or postpartum case manager and consist of an established curriculum for substance use risk reduction that shall:

(i) Increase the perception of personal risk for harm due to high-risk substance use throughout life;

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- (ii) Reduce the risk of substance use for pregnant individuals and/or individuals not greater than six (6) months postpartum, thus protecting their current and future children from subsequent risk for harm;
- (iii) Identify the known risks and potential consequences of substance use during pregnancy and throughout life;
- (iv) Address health and social consequences of high-risk behaviors related to substance use;
- (v) Address biological, psychological, and social factors that may increase risk for substance use during pregnancy, postpartum, and throughout life of the individual;
- (vi) Include a screening process for the identification of a pregnant individual or an individual not greater than six (6) months postpartum needing a referral for an indicated prevention education service or a substance use disorder assessment;
- (vii) Develop skills for making and maintaining behavioral changes associated with substance use and in developing social and psychological supports for these changes throughout life; or
- (viii) Limit reimbursement to a single pregnancy/postpartum episode and no more than seventeen (17) hours per lifetime for selective prevention education services for pregnant individuals and/or individuals not greater than six (6) months postpartum.

g. Indicated prevention education services shall be conducted by a prevention specialist or a pregnant or postpartum case manager and consist of an established curriculum for substance use risk reduction that shall:

- (i) Reduce the risk that pregnant individuals and/or individuals not greater than six (6) months postpartum may experience substance use related health problems, including substance dependency or experience substance use impairments throughout life;
- (ii) Address the health and social consequences of high-risk behaviors associated with substance use, including consequences to a fetus or baby in the case of any substance use during pregnancy and postpartum periods;
- (iii) Increase the perception of personal risk for harm due to high-risk behaviors associated with substance use;
- (iv) Identify the existence of biological, psychological, and social risk factors; and
- (v) Identify behaviors associated with substance use and the increased risks associated with those behaviors;
- (vi) Identify the known risks and potential consequences of substance use during pregnancy and throughout life;
- (vii) Developing skills for making and maintaining behavioral changes, including changes in substance use, and developing social and psychological supports to maintain the changes throughout life;
- (viii) Limit reimbursement to a single pregnancy or postpartum episode and no more than twenty five (25) hours per lifetime for indicated prevention services for pregnant individuals or individuals who are no more than six (6) months postpartum; and

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

(ix) Include a screening process for the identification of a pregnant individual or an individual not greater than six (6) months postpartum needing a referral for a substance use disorder assessment.

h. Prior to delivering a substance use risk reduction curriculum, a professional identified by this section of this manual as qualified to provide universal, selective, and indicated prevention education services shall:

- (i) Complete training requirements as mandated by DBHDID; and;
- (ii) Complete requirements of certification/licensing boards and;
- (iii) Be a qualified service provider of a CMHC; and be a
- (iv) Prevention Specialist; or
- (v) Pregnant or postpartum case manager.

i. All staff training hours required in clause h. of this subparagraph shall be documented in a staff member's training file and shall include the:

- (i) Date of the training;
- (ii) Length of the training event in clock hours;
- (iii) Learning objectives; and
- (iv) Name of the training provider.

24. Case Management Services for pregnant Individuals or individuals not greater than 6 months postpartum with a substance use disorder.

a. Eligibility requirements for case management services. An individual shall:

- (i) Meet the general eligibility criteria in 23.a.;
- (ii) Meet the criteria for a substance use disorder; and
- (iii) Need assistance in reducing barriers to entering and staying in substance use treatment or in accessing other resources that are needed to maximize functioning in the community.

b. Case management services shall be:

- (i) Provided to pregnant individuals or individuals not greater than 6 months postpartum with a mild, moderate, or severe substance use disorder diagnosis as indicated by a substance use disorder assessment;
- (ii) An ambulatory care service and contacts on behalf of the individual that consist of a minimum of one (1) face-to-face contact between the individual;
- (iii) For the purpose of reducing or eliminating a pregnant or postpartum individual's substance use by assisting the individual in gaining access to needed medical, social, educational and other recovery support services; and
- (iv) Limited to reimbursement for a period that is not longer than each pregnancy and than six (6) months postpartum.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

c. Case management services for pregnant individuals or individuals no longer than six (6) months postpartum shall include:

- (i) An inventory of an individual's case-management needs; and
- (ii) Development of an individualized person-centered service plan that identifies an individual's case management activities that support implementation of the case plan and goals established in the client's clinical assessment.

d. Case management services shall not be connected with a specific type of substance use treatment but shall follow an individual across the array of substance use treatment services identified in the individual's person-centered service plan;

e. A Case manager shall not exceed a caseload size of (25) unique clients;

f. Service limitations. The following activities shall not be reimbursed by this Medicaid benefit:

- (i) An outreach or case-finding activity to secure a potential individual for services;
- (ii) Administrative activities associated with Medicaid or eligibility determinations;
- (iii) Transportation services solely for the purpose of transporting the individual; and
- (iv) The actual provision of a service other than a case management service.

g. Documentation requirements. All staff training that is required shall be documented in a staff member's training file and shall include the:

- (i) Date of the training;
- (ii) Length of the training event in clock hours;
- (iii) Learning objectives; and
- (iv) Name of the training provider.

25. Withdrawal Management. TREATMENT OF SUBSTANCE USE ONLY.
Withdrawal management, for treatment of substance use only, shall:

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

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

c. Be in accordance with the most current version of *The ASAM Criteria* for withdrawal management levels in all settings.

- d.(i) If provided in an outpatient setting, comply with 908 KAR 1:374, Section 2; and
- (ii) If provided in a substance use disorder residential program, comply with 908 KAR 1:372, Section 2.

e. Provided to a recipient who:

- (i) Meets the most current edition of diagnostic criteria for substance withdrawal management found in the Diagnostic and Statistical Manual of Mental Disorders; and
- (ii) Meets the current dimensional admissions criteria for withdrawal management level of care as found in *The ASAM Criteria*.

f. Be provided by a physician, a psychiatrist, a physician assistant, an advance practice registered nurse or any other approved behavioral health practitioner with oversight by a physician, advanced practice nurse or a physician assistant.

26. Medication Assisted Treatment (Treatment of Substance Use Disorder Only)

a. Medication Assisted Treatment (MAT) shall be provided by an authorized prescribing provider who maintains a current waiver under 21 U.S.C. 823(g)(2), unless that requirement is waived or prescribing authority is otherwise expanded by the federal government, to prescribe buprenorphine products and who has experience and knowledge in addiction medicine, and who is:

- (i) A physician licensed to practice medicine under KRS Chapter 311;
- (ii) An advanced practice registered nurse who meets the standards in accordance with 201 KAR 9:270 or 201 KAR 20:065; or
- (iii) A physician's assistant licensed to practice pursuant to KRS Chapter 311.

b.(i) Medication assisted treatment with behavioral health therapies shall be co-located within the same practice site or via telehealth as appropriate according to 907 KAR 3:170 as the practitioner with a waiver under 21 U.S.C. 823(g)(2).

(ii) MAT shall be conducted with agreements in place for linkage to appropriate behavioral health treatment providers who specialize in substance use disorders and are knowledgeable in biopsychosocial dimensions of alcohol or other substance use disorders such as an approved behavioral health practitioner.

c. MAT services shall:

- (i) Assess the need for treatment including a full patient history to determine the severity of the patient's substance use disorder;
- (ii) Identify, and address any underlying or co-occurring diseases or condition;
- (iii) As necessary, educate the patient about how the medication works including the associated risks and benefits and overdose prevention;
- (iv) Evaluate the need for medically managed withdrawal from substances;
- (v) Refer patients for a higher level of care if necessary; and
- (vi) Obtain informed consent prior to integrating pharmacologic or non-pharmacologic therapies.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

d. Medication assisted treatment shall be available per patient choice for the treatment of a substance use disorder or co-occurring disorders.

e. To provide medication assisted treatment, a CMHC shall have:

- (i) The capacity to employ staff authorized to provide medication assisted treatment services in accordance with this section and to coordinate the provision of services among team members;
- (ii) The capacity to provide the full range of medication assisted treatment services;
- (iii) Demonstrated experience in serving individuals with substance use disorders;
- (iv) The administrative capacity to ensure quality of services;
- (v) A financial management system that provides documentation of services and costs;
- (vi) The capacity to document and maintain individual case records;

f. To provide medication assisted treatment, a CMHC shall:

- (i) Meet standards in accordance with 201 KAR 9:270 or 201 KAR 20:065; and
- (ii) Maintain current waiver under 21 U.S.C. Section 823(g) (2) to prescribe buprenorphine products, unless that requirement is waived or prescribing authority is otherwise expanded by the federal government.

27. Narcotic Treatment Program (NTP)

a. Narcotic Treatment Programs (NTP) are licensed organizations that provide MAT services for methadone in accordance with 908 KAR 1:370 and 908 KAR 1:374, or in a medication unit affiliated with an NTP.

- (i) A medication unit affiliated with an NTP includes a Medication Station or Dosing Location that obtains its Methadone drug supply from the main program site and retains all records, except dosing and drug screens, at the main location.
- (ii) The main program of a NTP is the location of the MAT program where all administrative and medical information related to the NTP is retained for the purpose of on-site reviews by federal agencies, the state narcotic authority, or state opioid treatment authority designee.

b. A NTP for the treatment of substance use disorders shall have the capacity to provide the full range of services included in the Medication Assisted Treatment definition and shall document supporting behavioral health services including:

- (i) Induction for Methadone or Buprenorphine;
- (ii) Medicated assisted treatment bundle for Methadone or Buprenorphine, which includes medication administration or dosing; presumptive drug class screening; individual outpatient therapy; group outpatient therapy; family outpatient therapy; intensive outpatient program, and assessment.
- (iii) Service planning;
- (iv) Peer support services; and

(v) Withdrawal management.

c. Temporary licensure shall be permitted for a certified alcohol and drug counselor practicing within a Narcotic Treatment Program (TCADC) as limited by this clause.

(i) A TCADC practicing within a Narcotic Treatment Program shall be under the direct supervision of a licensed clinical alcohol and drug counselor (LCADC).

(ii) Three (3) years after the effective date of the ordinary administrative regulation associated with this manual, TCADCs shall no longer be permitted to practice within a NTP.

(iii) After the three (3) year period discussed in sub-clause (ii) has lapsed, an individual performing certified alcohol and drug counselor duties shall possess an appropriate license to perform those duties.

28. Applied Behavior Analysis (ABA)

a. Applied Behavior Analysis (ABA) shall:

(i) Produce socially significant improvement in human behavior via the design, implementation and evaluation of environmental modifications, the use of behavioral stimuli and consequences and the use of direct observation, measurement and functional analysis of the relationship between the environment and the behavior.

(ii) Be an encounter between the provider and recipient with the exception of analyzing of past data and scoring or interpreting the assessment and preparing the report or treatment plan.

b. ABA shall be based on scientific research and the direct observation and measurement of the behavior and the environment, which utilize contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences to assist a recipient in:

(i) Developing new behaviors,

(ii) Increasing or decreasing existing behaviors; and

(iii) Eliciting behaviors under specific environmental conditions.

c. ABA services may apply principles, methods and procedures of the experimental analysis of behavior and applied behavior analysis, including applications of those principles, methods and procedures to:

(i) Design, implement, evaluate and modify treatment programs to change the behavior of individuals diagnosed with autism spectrum disorder,

(ii) Design, implement, evaluate and modify treatment programs to change the behavior of individuals;

(iii) Design, implement, evaluate and modify treatment programs to change the behavior of a group, or

(iv) Consult with individuals and organizations.

29. Laboratory Services

The CMHC shall have the appropriate CLIA certificate to perform laboratory testing pursuant to 907 KAR 1:028, provided that the laboratory services are prescribed by a physician, advanced practice registered nurse, or physician assistant who has a contractual relationship with the CMHC.

SECTION V. Limitations and Non-covered Services. (1) Limitations

(a) Recording an appropriate mental health or substance use disorder diagnosis in the recipient's record by the third (3rd) visit shall be required for Medicaid payment, with the exception of:

1. Crisis services;
2. Mobile crisis services;
3. PSS for the engagement in SUD treatment within an ED bridge clinic;
4. Screening; or
5. Assessment.

(b) Limits regarding Speech Disturbance Behavioral Health Services:

1. Medicaid shall reimburse the CMHC for the services of a psychiatrist or psychologist to a recipient with the diagnosis of a speech disturbance which is symptomatic of a psychiatric problem; and
2. Speech language pathology services shall be considered outside the scope of program benefits of the discipline providing speech therapy.

(c) Limits regarding Behavioral Health Services to Persons with an Intellectual Disability:

1. When the recipient's diagnosis is intellectual disability, the recipient shall have an additional psychiatric diagnosis substantiating the need for psychiatric treatment.
2. A diagnoses of developmental disorders, such as a learning disability, shall not be sufficient for the purposes of this paragraph.
3. Services rendered to persons with intellectual disabilities in need of psychiatric services shall be covered by Medicaid when rendered in accordance with the psychiatrist's plan of care.
4. The staff note shall document the psychiatric treatment rendered.

(d) Limits regarding Group Outpatient Therapy:

1. Group outpatient therapy services shall be limited to groups of twelve (12) or fewer recipients per mental health center staff.
2. Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day per recipient, but may be exceeded based on medical necessity.

(e) Limits regarding Individual Outpatient Therapy. Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day per recipient, but can be exceeded based on medical necessity.

(f) Limits regarding Family Outpatient Therapy. Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

day per recipient, but can be exceeded based on the individual's plan of care and medical necessity.

(2) Non-Covered Services. The following services or activities shall not be covered under 907 KAR 1:044:

(a) A service provided to:

1. A resident of:

a. A nursing facility; or

b. An intermediate care facility for individuals with an intellectual disability;

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

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

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the behavioral health services organization;

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

(d) Travel time;

(e) A field trip;

(f) A recreational activity;

(g) A social activity; or

(h) A physical exercise activity group.

(i) A consultation by one (1) provider or professional with another shall not be covered under 907 KAR 1:044 except for a collateral outpatient therapy consultation.

(j) For a recipient receiving ACT, the following shall not be billed or reimbursed for the same date of service for the recipient:

1. An assessment;

2. Case management;

3. Individual outpatient therapy;

4. Group outpatient therapy;

5. Peer support services; or

6. Mobile crisis services.

(k) A third party contract.

(l) A screening and a SBIRT provided to a recipient on the same date of service shall not be covered.

(m) For a recipient receiving residential services for SUD, the following shall not be billed or reimbursed for the same date of service for the recipient:

1. A screening;

2. An assessment;

3. Service planning;

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

- 4. A psychiatric service;
- 5. Individual outpatient therapy, group outpatient therapy, family outpatient therapy or peer support services.
 - (n) A billing supervisor arrangement between a billing supervisor and an approved behavioral health practitioner under supervision that violates the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the approved behavioral health practitioner under supervision.
 - (o) Mobile crisis services that are provided for more than twenty-four (24) hours.
- (3) Covered services require direct contact between a practitioner and a recipient except for:
 - (a) Collateral outpatient therapy services for a recipient under age twenty-one (21), when a part of the plan of care;
 - (b) A family outpatient therapy service in which the corresponding current procedural terminology code establishes that the recipient is not present;
 - (c) A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or others in which corresponding current procedural terminology code establishes that the recipient is not present;
 - (d) A service planning activity in which the corresponding current procedural terminology code establishes that the recipient is not present.
 - (e) ABA service of analyzing of past data and scoring or interpreting the assessment and preparing the report and/or treatment plan.
 - (f) For additional services, see Section IV of this manual.
- (4)(a) These limitations and non-covered services shall be monitored by DMS using a combination of system edits during claims processing and of post-payment reviews and audits.
- (b) Payment for any services provided outside of the scope of covered benefits shall be refunded to DMS.

VI. MISCELLANEOUS CLAIMS REQUIREMENTS

- (1) Accident and Work Related Claims:
 - (a) For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident.
 - (b) If an attorney, employer, individual or an insurance company is liable for payment, payment shall be pursued from the liable party.
 - (c) If the liable party has not been determined, the CMHC shall attach copies of any information obtained, such as the names of attorneys, other involved parties, or the recipient's employer to the claim when submitted to DMS' fiscal agent for Medicaid payment.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

(2) Claims Over Twelve Months Old:

(a) Claims with service dates more than twelve (12) months old shall not be eligible for processing or reimbursement unless appropriate documentation, such as one (1) or more of the following:

1. Remittance statements which verify timely filing;
2. Medicare Explanation of Medical Benefits (EOMB's);
3. Medicare Explanation of Benefits (EOB's); and
4. Commercial insurance.

(b) Without documentation required pursuant to paragraph (a) above, claims over twelve (12) months old shall be denied.

APPENDIX A: Authorized Practitioners by Service

A. Individual Outpatient Therapy

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

B. Group Outpatient Therapy

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

C. Family Outpatient Therapy

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

D. Collateral Outpatient Therapy Services

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

E. Crisis Intervention Services

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

F. Mobile Crisis Services

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Certified Peer Support Specialist under supervision.

G. Therapeutic Rehabilitation Services TREATMENT FOR MENTAL HEALTH ONLY.

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

H. Psychological Testing

1. Licensed Psychologist.
2. Licensed Psychological Practitioner.
3. Licensed Psychological Associate.
4. Certified Psychologist.
5. Certified Psychologist with Autonomous Functioning.
6. Approved behavioral health practitioner qualified to conduct psychological testing.

I. Screening

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Prevention Specialist under supervision.
6. Pregnant and/or postpartum case manager under supervision.

J. Assessment

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

K. Partial Hospitalization

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.

L. Service Planning

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

M. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

N. Assertive Community Treatment (ACT) TREATMENT FOR MENTAL HEALTH ONLY

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Community Support Associate under supervision.
6. Certified Peer Support Specialist under supervision.

O. Intensive Outpatient Program Services (IOP)

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

P. Residential Services for Substance Use Disorders

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Certified Peer Support Specialist under supervision.

Q. Inpatient services under a Chemical Dependency Treatment Center (CDTC) License

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Certified Peer Support Specialist under supervision.

R. Residential Crisis Stabilization Services

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Certified Peer Support Specialist under supervision.

S. Day Treatment

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Certified Peer Support Specialist under supervision.

T. Peer Support Services

1. Adult Peer Support Specialist under supervision.
2. Family Peer Support Specialist under supervision.
3. Youth Peer Support Specialist under supervision.
4. Registered Alcohol and Drug Peer Support Specialist under supervision.

U. Comprehensive Community Support Services TREATMENT FOR MENTAL HEALTH ONLY

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Professional Equivalent under supervision.
4. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.
5. Community Support Associate under supervision.

V. Prevention Education services for Substance Use Risk Factors and Pregnant or Postpartum Case Management

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Prevention Specialist under supervision.
4. Pregnant and/or postpartum case manager under supervision.

W. Withdrawal Management

1. Psychiatrist.
2. Physician.
3. Psychiatric Resident.
4. Resident Physician.
5. APRN.
6. Physician Assistant.
7. Approved Behavioral Health Practitioner.
8. Approved Behavioral Health Practitioner under supervision.

X. Medication Assisted Treatment (MAT)

1. Psychiatrist.
2. Physician.
3. Psychiatric Resident.
4. Resident Physician.
5. APRN.
6. Physician Assistant.
7. Approved Behavioral Health Practitioner.
8. Approved Behavioral Health Practitioner under supervision.
9. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

Y. Narcotic Treatment Program (NTP, MUST BE A LICENSED NTP)

1. Approved Behavioral Health Practitioner.
2. Approved Behavioral Health Practitioner under supervision.
3. Mental Health Associate under supervision, as limited by Section III.B.9. of this manual.

Z. Applied Behavior Analysis (ABA)

1. Licensed Behavioral Analyst.
2. Licensed Assistant Behavioral Analyst.
3. Approved behavioral health practitioner with documented training in ABA.
4. Approved behavioral health practitioner under supervision with documented training in ABA.
5. RBT under the supervision of a LBA.

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

APPENDIX B: MHA APPLICATION

CMHC Mental Health Associate (MHA)

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment #

_____ *City State ZIP Code*

Phone: _____ Email _____

Education

Under Graduate School: _____ Address: _____

From: _____ To: _____ Did you graduate? Yes No Degree: _____

Graduate School: _____ Address: _____

From: _____ To: _____ Expectant Graduation Date: _____ Expectant Degree: _____

Current CMHC or Applying CMHC

CMHC: _____ Phone: _____
Address: _____ Supervisor: _____

List Responsibilities:

Cabinet for Health and Family Services
Department for Medicaid Services
Behavioral Health Services Manual for Community Mental Health Centers
April 2022

Certifications, if applicable

Certification or License: _____

Date Issued: _____

Renewal Date: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____