KENTUCKY TELEHEALTH & TELEMEDICINE LAWS

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
TELEHEALTH BOARD		
KRS 194A.125 (Eff. 7-12-2012) www.lrc.ky.gov/Statutes/statute.aspx?id=40938	Telehealth Board – Members – Chair – Scope of administrative regulations – Board to make recommendations following consultation with Governor's office – Universities of Kentucky and Louisville to report to General Assembly – Receipt and dispensing of funds.	**10 KAR 3:020**. Establishing and funding telehealth network training centers. (Eff. 7-16-2001) www.lrc.ky.gov/kar/010/003/020.htm **10 KAR 3:030**. Establishing and funding telehealth network rural sites. (Eff. 7-16-2001) www.lrc.ky.gov/kar/010/003/030.htm **10 KAR 3:050**. Establishing protocols and standards for telehealth network training centers and rural sites. (Eff. 3-19-2003) www.lrc.ky.gov/kar/010/003/050.htm
KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS		
KRS 312.220 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=30803	Duty of treating chiropractor utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	
KENTUCKY BOARD OF SOCIAL WORK		
KRS 335.158 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31935	Duty of treating clinical social worker utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	
DEPARTMENT OF CORRECTIONS		
KRS 197.020 (Eff. 6-08-2011) www.lrc.ky.gov/Statutes/statute.aspx?id=39547	Administrative regulations to be promulgated by Department of Corrections – Fee for use of medical facilities – Reimbursement of telehealth consultations – Use of jail medical facilities	**501 KAR 3:090**. Medical Services. (Eff. 3-04-2016) www.lrc.ky.gov/kar/501/003/090.htm **501 KAR 7:090**. Medical Services. (Eff. 10-07-2011) www.lrc.ky.gov/kar/501/007/090.htm

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
	by state prisoner governed by KRS 441.045.	**501 KAR 7:010**. Definitions for 501 KAR Chapter 7. (Eff. 3-4-2016) www.lrc.ky.gov/kar/501/007/010.htm **501 KAR 13:010**. Life Safety Issues. (Eff. 10-07-2011) www.lrc.ky.gov/kar/501/013/010.htm
KENTUCKY BOARD OF DENTISTRY		
KRS 313.010 (Eff. 7-15-2010) www.lrc.ky.gov/Statutes/statute.aspx?id=30806	Definitions for chapter	
KRS 313.060 (Eff. 7-15-2010) www.lrc.ky.gov/Statutes/statute.aspx?id=30815	Administrative regulations governing minimal requirements for documentation, oath for disease control compliance, sedation of patients, and compliance with federal statutes and regulations – Death or incapacity of dentist – Telehealth – Continuing education.	
KENTUCKY BOARD OF LICENSURE & CERTIFICATION FOR DIETITIANS & NUTRITIONISTS		
KRS 310.200 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=30392	Duty of treating dietitian or nutritionist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 33:070**. Telehealth and telepractice. (Eff. 6-06-2014) www.lrc.ky.gov/kar/201/033/070.htm
DEPARTMENT OF INSURANCE		
KRS 304.17A-005 (Eff. 7-15-2016 www.lrc.ky.gov/Statutes/statute.aspx?id=45258	Definitions for subtitle.	
KRS 304.17A-138 (Eff. 7-15-2010) www.lrc.ky.gov/Statutes/statute.aspx?id=17373	Prohibition against health benefit plan excluding coverage for telehealth – Benefits subject to deductible, co-payment, or	**806 KAR 17:270**. Telehealth claim forms and records. (Eff. 8-09-2007) www.lrc.ky.gov/kar/806/017/270.htm

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
	coinsurance – Payment subject to provider network arrangements – Administrative regulations.	**806 KAR 17:500**. Basic health benefit plan requirements. (Eff. 12-05-2008) www.lrc.ky.gov/kar/806/017/500.htm
KENTUCKY BOARD OF MARRIAGE AND FAMILY THERAPISTS		
KRS 335.380 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31954	Duty of treating marriage and family therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	
DEPARTMENT FOR MEDICAID SERVICES		
KRS 205.510 (Eff. 6-20-2005) www.lrc.ky.gov/Statutes/statute.aspx?id=7695	Definitions for medical assistance law.	
KRS 205.520 (Eff. 6-20-2005) www.lrc.ky.gov/Statutes/statute.aspx?id=7700	Title and purpose of KRS 205.510 to 205.630 – Recovery from third parties for services rendered.	**907 KAR 1:055**. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services. (Eff. 11-06-2015) www.lrc.ky.gov/kar/907/001/055.htm **907 KAR 3:005**. Coverage of physicians' services. (Eff. 3-06-2015) www.lrc.ky.gov/kar/907/003/005.htm **907 KAR 3:010**. Reimbursement for physicians' services. (Eff. 4-11-2012) www.lrc.ky.gov/kar/907/003/010.htm
KRS 205.559 (Eff. 7-15-2001) www.lrc.ky.gov/Statutes/statute.aspx?id=7707	Requirements for Medicaid reimbursement to participating providers for telehealth consultations – Report of impact on health care delivery system required – Administrative regulations.	**907 KAR 3:170**. Telehealth consultation coverage and reimbursement. (Eff. 5-03-2013) www.lrc.ky.gov/kar/907/003/170.htm **907 KAR 9:005**. Non-outpatient Level I and II psychiatric residential

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
		treatment facility service and coverage policies. (Eff. 11-16-2015) www.lrc.ky.gov/kar/907/009/005.htm
KRS 205.632 (Eff. 7-15-2016) www.lrc.ky.gov/Statutes/statute.aspx?id=45357	Pilot project to create coverage provisions and reimbursement criteria for telemonitoring services based on evidence-based best practices provided by a qualified medical provider or community action agency.	
KENTUCKY BOARD OF NURSING		
KRS 314.155 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=30935	Duty of treating nurse utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 20:520**. Telehealth. (Eff. 7-20-2016) www.lrc.ky.gov/kar/201/020/520.htm
KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY		
KRS 319A.300 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31275	Duty of treating occupational therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 28:230**. Telehealth occupational therapy services (PENDING – FILED 11-15-2016) www.lrc.ky.gov/kar/201/028/230reg.htm
KENTUCKY BOARD OF OPTOMETRIC EXAMINERS		
KRS 320.390 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31352	Duty of treating optometrist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 5:055**. Telehealth. (Eff. 11-19-2014) www.lrc.ky.gov/kar/201/005/055.htm
KENTUCKY BOARD OF PHARMACY		
KRS 315.310 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31038	Duty of treating pharmacist utilizing telehealth to ensure patient's informed consent	

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
	and maintain confidentiality -- Board to promulgate administrative regulations – Definition of "telehealth."	
KENTUCKY BOARD OF PHYSICAL THERAPY		
KRS 327.200 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31724	Duty of treating physical therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 22:160**. Telehealth and telephysical therapy. (Eff. 8-01-2014) www.lrc.ky.gov/kar/201/022/160.htm
PHYSICIANS, OSTEOPATHS, PODIATRISTS & RELATED MEDICAL PRACTITIONERS		
KRS 311.550 (Eff. 7-12-2006) www.lrc.ky.gov/Statutes/statute.aspx?id=30519	Definitions for KRS 311.530 to 311.620 and KRS 311.990 (4) to (6)	
KRS 311.560 (Eff. 6-25-2009) www.lrc.ky.gov/Statutes/statute.aspx?id=30521	Prohibition against practice of medicine or osteopathy without license – Exceptions	
KRS 311.5975 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=30539	Duty of treating physician utilizing telehealth to insure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations.	
KRS 311.724 (Eff. 7-15-2016) www.lrc.ky.gov/Statutes/statute.aspx?id=44918	Informed consent given in "individual, private setting."	
KENTUCKY BOARD OF EXAMINERS OF PSYCHOLOGY		
KRS 319.140 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31252	Duty of treating psychologist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 26:310.** Telehealth and telepsychology. (Eff. 3-04-2011) www.lrc.ky.gov/kar/201/026/310.htm
CABINET FOR HEALTH AND FAMILY SERVICES		
KRS 211.195 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=8363	Authorization for Department for Public Health to develop programs	**902 KAR 20:091**. Facilities specifications, operation and

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
	allowing local health departments to participate in telehealth and receive reimbursement.	services; community mental health center. (Amended at ARRS 3-06-2017) www.lrc.ky.gov/kar/902/020/091.htm **902 KAR 20:440.** Facilities specifications, operation and services; residential crisis stabilization units. (Eff. 12-17-2014) www.lrc.ky.gov/kar/902/020/440.htm **902 KAR 100:017**. Special requirements for teletherapy licenses. (Eff. 6-27-1990) www.lrc.ky.gov/kar/902/100/017.htm
KRS 218A.010 (Eff. 4-27-2016) www.lrc.ky.gov/Statutes/statute.aspx?id=44884	Definitions for chapter.	
KENTUCKY BOARD OF RESPIRATORY CARE		
KRS 314A.230 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=30985	Duty of treating respiratory care practitioner utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	
KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY		
KRS 334A.200 (Eff. 7-14-2000) www.lrc.ky.gov/Statutes/statute.aspx?id=31917	Duty of treating speech-language pathologist or audiologist utilizing telehealth to ensure patient's informed consent and maintain confidentiality – Board to promulgate administrative regulations – Definition of "telehealth."	**201 KAR 17:110**. Telehealth and telepractice. (Eff. 3-08-2013) www.lrc.ky.gov/kar/201/017/110.htm
DEPARTMENT OF WORKERS' CLAIMS		
KRS 342.315 (Eff. 7-15-2010) www.lrc.ky.gov/Statutes/statute.aspx?id=32471	Medical evaluations by university medical schools – Procedures – Report –	

STATUTES	TITLE	ADMINSTRATIVE REGULATIONS
	Payment of costs – Performance assessment of medical schools.	
KENTUCKY APPLIED BEHAVIOR ANALYSIS LICENSING BOARD		
KRS 319C.140 (Eff. 7-15-2010) www.lrc.ky.gov/Statutes/statute.aspx?id=31305	Patient's informed consent – Confidentiality of medical information – Administrative regulations governing telehealth services.	**201 KAR 43:100.** Telehealth and telepractice. (Eff. 8-01-2014) www.lrc.ky.gov/kar/201/043/100.htm
HOSPITALIZATION OF THE MENTALLY ILL		
KRS 202A.028 (Eff. 6-24-2015) www.lrc.ky.gov/Statutes/statute.aspx?id=44467	Hospitalization by court order – Transportation – Release.	
RELIGIOUS, CHARITABLE, AND EDUCATIONAL SECURITIES – NONSTOCK, NONPROFIT CORP		
KRS 273.442 (Eff. 7-15-2016) www.lrc.ky.gov/Statutes/statute.aspx?id=45359	Community action agency may participate in pilot project established in KRS 205.632	

KENTUCKY BOARD OF MEDICAL LICENSURE

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine
(*Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup of the Federation of State Medical Boards)* - Adopted April 2014)
http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

KENTUCKY TELEHEALTH BOARD

KRS 194A.125. Telehealth Board -- Members -- Chair -- Scope of administrative regulations -- Board to make recommendations following consultation with Governor's office -- Universities of Kentucky and Louisville to report to General Assembly -- Receipt and dispensing of funds.
www.lrc.ky.gov/Statutes/statute.aspx?id=40938

(1) The Telehealth Board is created and placed for administrative purposes under the cabinet. This ten (10) member board shall consist of the:
   (a) Chancellor, or a designee, of the medical school at the University of Kentucky;
   (b) Chancellor, or a designee, of the medical school at the University of Louisville;
   (c) Commissioner, or a designee, of the Department for Public Health;
   (d) Executive director, or a designee, of the Commonwealth Office of Technology;
   (e) Executive director, or a designee, of the Office of Administrative and Technology Services, Cabinet for Health and Family Services; and
   (f) Five (5) members at large, appointed by the Governor, who are health professionals or third parties as those terms are defined in KRS 205.510. To ensure representation of both groups, no more than three (3) health professionals or two (2) third parties shall be members of the board at the same time. These members shall serve a term of four (4) years, may serve no more than two (2) consecutive terms, and shall be reimbursed for their costs associated with attending board meetings.

(2) The members shall elect a chair and hold bimonthly meetings or as often as necessary for the conduct of the board's business.

(3) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to:
   (a) Establish telehealth training centers at the University of Kentucky, University of Louisville, the pediatric-affiliated hospitals at the University of Kentucky and the University of Louisville, and one (1) each in western Kentucky and eastern Kentucky, with the sites to be determined by the board;
   (b) Develop a telehealth network, to coordinate with the training centers, of no more than twenty-five (25) rural sites, to be established based on the availability of funding and in accordance with criteria set by the board. In addition to these rural sites, the board may identify, for participation in the telehealth network, ten (10) local health departments, five (5) of which shall be administered by the University of Kentucky and five (5) of which shall be administered by the University of Louisville, and any other site that is operating as a telemedicine or telehealth site and that demonstrates its capability to follow the board's protocols and standards;
   (c) Establish protocols and standards to be followed by the training centers and rural sites; and
   (d) Maintain the central link for the network with the Kentucky information highway.

(4) The board shall, following consultation with the Commonwealth Office of Technology, recommend the processes and procedures for the switching and running of the telehealth network.

(5) The University of Kentucky and the University of Louisville shall report semiannually to the Interim Joint Committee on Health and Welfare on the following areas as specified by the board through an administrative regulation promulgated in accordance with KRS Chapter 13A.
   (a) Data on utilization, performance, and quality of care;
   (b) Quality assurance measures, including monitoring systems;
   (c) The economic impact on and benefits to participating local communities; and
   (d) Other matters related to telehealth at the discretion of the board.
(6) The board shall receive and dispense funds appropriated for its use by the General Assembly or obtained through any other gift or grant.

Effective: July 12, 2012

History: Amended 2012 Ky. Acts ch. 158, sec. 16, effective July 12, 2012. -- Repealed, reenacted, and amended 2007 Ky. Acts ch. 24, sec. 25, effective June 26, 2007. -- Amended 2006 Ky. Acts ch. 143, sec. 1, effective July 12, 2006. -- Amended 2005 Ky. Acts ch. 85, sec. 37, effective June 20, 2005. -- Amended 2001 Ky. Acts ch. 47, sec. 1, effective June 21, 2001; and ch. 57, sec. 1, effective June 21, 2001. – Created 2000 Ky. Acts ch. 376, sec. 2, effective July 14, 2000. **Formerly codified as KRS 11.550.**

Telehealth Board - 10 KAR 3:020. Establishing and funding telehealth network training centers. www.lrc.ky.gov/kar/010/003/020.htm

RELATES TO: KRS 11.550, 45A.605, 197.020, 205.510, 205.559, 211.195, 304.17A-005, 304.17A-138, 310.200, 311.550, 311.5975, 312.220, 313.255, 314.155, 314A.230, 315.310, 319.140, 319A.300, 320.390, 327.200, 334A.200, 335.158, 335.380

STATUTORY AUTHORITY: KRS 11.550(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 11.550(3) requires the Telehealth Board to promulgate administrative regulations relating to the establishment of telehealth training centers, the development of a telehealth network of rural sites, the establishment of protocols and standards to be followed by the training centers and rural sites, and the maintenance of the central link for the network with the Kentucky information highway. This administrative regulation establishes the telehealth training centers at the University of Kentucky, University of Louisville, the pediatric-affiliated hospitals at the University of Kentucky and the University of Louisville, and one (1) each in western Kentucky and eastern Kentucky.

Section 1. Training Center Basic Criteria.

(1) The training centers shall be established by the board for the purpose of promoting telehealth activities.
(2) The training centers shall be equipped and staffed to provide technical training for telehealth applications.
(3) The training centers shall oversee the development of continuing education programs designed to familiarize practitioners throughout the Commonwealth with telehealth applications.
(4) The training centers shall train practitioners implementing telehealth applications.

(5) The training centers shall meet clinical, professional, and technical standards as determined by the Telehealth Board.

Section 2. University Training Center Participation. The training centers at the University of Kentucky and the University of Louisville shall be awarded funding once a Memorandum of Agreement (MOA) is entered into between the university and the Telehealth Board for that purpose.

Section 3. Other Training Center Participation. The training center sites in western Kentucky and eastern Kentucky shall be determined by the Telehealth Board pursuant to the provisions of KRS Chapter 45A.

Section 4. Disbursement of Funds. Disbursement of funds shall be determined by the Telehealth Board based on the availability of funding.

Section 5. Reporting Requirements. The training centers shall submit semi-annual progress reports to the Telehealth Board based on criteria developed by the Telehealth Board. (27 Ky.R. 3181; 28 Ky.R. 65; **eff. July 16, 2001**.)

Telehealth Board - 10 KAR 3:030. Establishing and funding telehealth network rural sites.

http://www.lrc.ky.gov/kar/010/003/030.htm

RELATES TO: KRS 11.550, 45A.605, 197.020, 205.510, 205.559, 211.195, 304.17A-005, 304.17A-138, 310.200, 311.550, 311.5975, 312.220, 313.255, 314.155, 314A.230, 315.310, 319.140, 319A.300, 320.390, 327.200, 334A.200, 335.158, 335.380

STATUTORY AUTHORITY: KRS 11.550(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 11.550(3) requires the Telehealth Board to promulgate administrative regulations relating to the establishment of telehealth training centers, the development of a telehealth network of rural sites, the establishment of protocols and standards to be followed by the training centers and rural sites, and the maintenance of the central link for the network with the Kentucky information highway. This administrative regulation establishes a telehealth network, to coordinate with the training centers, of no more than twenty-five (25) rural sites, to be established based on the availability of funding and in accordance with criteria set by the board. In addition to these rural sites, the board may identify, for participation in the Telehealth Network, ten (10) local health departments, five (5) of which shall be administered by the University of Kentucky and five (5) of which shall be administered by the University of Louisville. This administrative regulation also establishes basic criteria therefor.

Section 1. Definitions.

(1) "Health care facility" means a hospital including a physical health hospital, psychiatric hospital, or rehabilitation center; or a clinic, private practitioner's office, public health facility, nursing home or assisted living center, community mental health/mental retardation facility, school clinic,

correctional facility clinic, and other facilities that normally provide health care services such as an outpatient dialysis center; or a patient's home for home health services.

(2) "Health professional(s) shortage area (HPSA)" means:
   (a) An urban or rural area;
   (b) A population group; or
   (c) A public or private nonprofit medical facility or other public facility that has a shortage of health-care professionals as determined by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 CFR Part 5.

(3) "Medically-underserved area (MUA)" means an urban or rural area designated by the Secretary of the U.S. Department of Health and Human Services as an area with a shortage of personal health services, or a population group designated by the Secretary of the U.S. Department of Health and Human Services as having a shortage of such services pursuant to 42 CFR Part 51c.

(4) "Rural site" means a health care facility in a county with a population of less than 100,000 people, based on the 1990 Census Data developed by the State Data Center at the University of Louisville, that serves as a regional health care provider to one (1) or more counties designated as a health professional shortage area (HPSA) or medically-underserved area (MUA), or is a designated HPSA or MUA county as identified by the Bureau for Health Care Data Services (BHCDSNet), updated 8/07/2000.

(5) "Telehealth" means the use of interactive audio, video, or other electronic media to improve access to health resources including the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Section 2. Rural Sites Basic Criteria. To be selected as a rural site on the Telehealth Network, the following criteria shall be met:

(1) The site shall be defined as a health care facility.
(2) The site shall meet the definition of a rural site.
(3) The site shall comply with all federal and state laws and regulations relating to health care facilities.
(4) The site shall be required to sign and comply with all terms and conditions contained in its contract with the board.
(5) The site shall comply with all criteria, protocols, and standards as set forth by the board.

Section 3. Rural Site Selection Process. The Telehealth Board shall make the rural site selections pursuant to the provisions of KRS Chapter 45A and based on the availability of funding.

Section 4. Local Health Department Selection Process. The Telehealth Board shall make the local health department selections pursuant to criteria established by the Telehealth Board for that purpose and based on the availability of funding. Local health departments so selected will enter into a Memorandum of Agreement (MOA) between the local health department, the Telehealth Board, and the University that will administer the program.

Section 5. Disbursement of Funds. Disbursement of funds shall be determined by the Telehealth Board based on the availability of funding. Successful applicants shall be notified pursuant to the provisions of KRS Chapter 45A.

Section 6. Reporting Requirements. The Telehealth Network rural sites shall submit semiannual progress reports to the Telehealth Board based on criteria developed by the Telehealth Board. (27 Ky.R. 3182; Ky.R. 65; **eff. July 16, 2001**.)

Telehealth Board - 10 KAR 3:050. Establishing protocols and standards for telehealth network training centers and rural sites. www.lrc.ky.gov/kar/010/003/050.htm

RELATES TO: KRS 11.550, 45A.605, 197.020, 205.510, 205.559, 211.195, 304.17A-005, 304.17A-138, 310.200, 311.550, 311.5975, 312.220, 313.255, 314.155, 314A.230, 315.310, 319.140, 319A.300, 320.390, 327.200, 334A.200, 335.158, 335.380

STATUTORY AUTHORITY: KRS 11.550(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 11.550(3) requires the Telehealth Board to promulgate administrative regulations to establish telehealth training centers, develop a telehealth network of rural sites, establish protocols and standards to be followed by the training centers and rural sites, and to maintain the central link for the network with the Kentucky information highway. This emergency administrative regulation establishes protocols and standards to be followed by the training centers and rural sites.

Section 1. Definitions.

(1) "Consulting clinician" means a clinician who, using telehealth technology, examines a patient, from a site distant from the patient, while the patient is located at a presenting site.
(2) "Presenter" means a person with the patient during the time of the encounter, who aids in the examination by following the orders of the consulting clinician, including the manipulation of cameras and appropriate placement of other peripheral devices used to conduct the patient examination.
(3) "Referring clinician" means a clinician who requests a patient be seen, via telehealth, by a consulting clinician.
(4) "Teleclinic" means the block of time that a consulting clinician has set aside for the examination of patients by means of telehealth.
(5) "Telehealth" is defined at KRS 310.200.
(6) "Telehealth encounter" means the use of telehealth equipment to bring a patient from a presenting site together with a consulting clinician for the purposes of evaluation and treatment.

Section 2. Protocols and Standards.

(1) Every rural site and every telehealth training center shall participate in the development and operation of clinical services for the benefit of its patients by:
    (a) Promoting the referral of patients to existing telehealth clinics;
    (b) Developing new telehealth clinics; and
    (c) Seeking to recruit consulting clinicians to perform telehealth services.
(2) A telehealth encounter shall be:

(a) Guided by the consulting clinician; and
(b) Interactive, except for an application not normally interactive, such as:
1. Radiology;
2. Pathology; and
3. Echocardiography.

(3) The clinical staff at the presenting site shall recommend the clinical services to be provided by telehealth in accordance with the Joint Commission on Accreditation of Healthcare Organizations Medical Staff Standard MS.5.16.1.

(4) The referring clinician, consulting clinician, and the patient or the patient's family may decline telehealth services in favor of a traditional face-to-face encounter.

(5) The consulting clinician shall determine:
(a) If a presenter is medically necessary for the encounter; and
(b) The qualifications required for a presenter medically necessary to the encounter.

(6) Each rural site and training center shall have a trained clinical presenter to conduct telehealth encounters.

(7) (a) The Telehealth Board shall develop clinical application policy and procedure, with input from the presenting and consulting sites, presenting and consulting clinicians, and the telehealth training centers.
(b) Protocols and procedures shall include:
1. The determination of who is appropriate to be a consulting clinician;
2. What process shall be followed to refer a patient into the clinic;
3. Whether the consulting clinician shall accept ad hoc or urgent encounters outside the normal teleclinic;
4. What resources are required at the presenting and consulting sites to conduct the teleclinic;
5. What training shall be required at the presenting and consulting sites to conduct the teleclinic;
6. What paperwork is necessary; and
7. What the response time shall be for reporting the consulting clinician's findings to the referring clinician.

(8) The training centers shall work together to develop a scheduling process and shall draft documentation regarding schedule format and how the schedule shall be managed. The scheduling process and all collateral material shall require the approval of the Telehealth Board prior to implementation.

(9) The telehealth training centers shall work together to draft documentation requirements for telehealth encounters. This shall include what information is required from the referring clinician, what information is required from the patient and what follow-up information is to be sent from the consulting clinician back to the referring clinician. The training centers shall also determine appropriate guidelines for when this information is to be collected and disseminated. All such documentation and processes regarding telehealth encounters shall require the approval of the Telehealth Board prior to implementation.

(10) Patients and consultants shall complete the approved evaluation form for all telehealth encounters and shall be responsible for sending that information to the proper place for compilation and reporting.
(11) All patients shall complete consent forms regarding their use of the telehealth network as well as their participation in the evaluation project, and the presenting site shall insure that all informed consent documentation is properly completed and sent to the proper place for compilation and reporting.
(12) The telehealth training centers shall draft documentation and processes to insure the privacy and confidentiality of telehealth patients and their medical information. The training centers, as well as the Telehealth Board, shall continue ongoing review of the Health Insurance Portability and Accountability Act guidelines to insure the network is in compliance. All such documentation and processes shall require the approval of the Telehealth Board prior to implementation.
(13) The training centers shall draft documentation and processes to insure that the network remains in compliance with all Joint Commission on Accreditation of Healthcare Organizations' credentialing and privileging requirements, as well as all applicable state and federal regulatory bodies. These processes shall require the approval of the Telehealth Board.

Section 3. Incorporation by Reference.
(1) "Joint Commission on Accreditation of Healthcare Organizations Medical Staff Standard MS.5.16.1 (January 2001)" is incorporated by reference.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Governor's Office of Technology, 193 Versailles Road, Suite 63, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (29 Ky.R. 1423, 2265; **eff. March 19, 2003**.)

KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

KRS 312.220. Duty of treating chiropractor utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=30803

(1) A treating chiropractor who provides or facilitates the use of telehealth shall ensure:
  (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
  (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.
(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
  (a) Prevent abuse and fraud through the use of telehealth services;
  (b) Prevent fee-splitting through the use of telehealth services; and

(c) Utilize telehealth in the provision of chiropractic services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000

History: Created 2000 Ky. Acts ch. 376, sec. 11, effective July 14, 2000.

KENTUCKY BOARD OF SOCIAL WORK

KRS 335.158. Duty of treating clinical social worker utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31935

(1) A treating clinical social worker who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of clinical social work services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000

History: Created 2000 Ky. Acts ch. 376, sec. 20, effective July 14, 2000.

DEPARTMENT OF CORRECTIONS

KRS 197.020. Administrative regulations to be promulgated by Department of Corrections -- Fee for use of medical facilities -- Reimbursement of telehealth consultations -- Use of jail medical facilities by state prisoner governed by KRS 441.045. www.lrc.ky.gov/Statutes/statute.aspx?id=39547

(1) The Department of Corrections shall:
   (a) Promulgate administrative regulations for the government and discipline of the penitentiary, for the government and official conduct of all officials connected with the penitentiary, and for the government of the prisoners in their deportment and conduct;
   (b) Promulgate administrative regulations for the character of food and diet of the prisoners; the preservation of the health of the prisoners; the daily cleansing of the penitentiary; the cleanliness of the persons of the prisoners; the general sanitary government of the penitentiary and prisoners; the character of the labor; the quantity of food and clothing; and the length of time during which the prisoners shall be employed daily;
   (c) Promulgate administrative regulations, as the department deems necessary, for the disposition of abandoned, lost, or confiscated property of prisoners;
   (d) Promulgate administrative regulations for the administration of a validated risk and needs assessment to assess the criminal risk factors and correctional needs of all inmates upon commitment to the department; and
   (e) Cause the administrative regulations promulgated by the department, together with the law allowing commutation of time to prisoners for good conduct, to be printed and posted in conspicuous places in the cell houses and workshops.

(2) The department may impose a reasonable fee for the use of medical facilities by a prisoner who has the ability to pay for the medical and dental care. These funds may be deducted from the prisoner's inmate account. A prisoner shall not be denied medical or dental treatment because he has insufficient funds in his inmate account.

(3) The department may promulgate administrative regulations in accordance with KRS Chapter 13A to implement a program that provides for reimbursement of telehealth consultations.

(4) Fees for the use of medical facilities by a state prisoner who is confined in a county jail pursuant to KRS 532.100 or other statute shall be governed by KRS 441.045.

Effective: June 8, 2011

History: Amended 2011 Ky. Acts ch. 2, sec. 27, effective June 8, 2011. – Amended 2010 Ky. Acts ch. 8, sec. 2, effective July 15, 2010. -- Amended 2007 Ky. Acts ch. 85, sec. 231, effective June 26, 2007. -- Amended 2000 Ky. Acts ch. 376, sec. 23, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 406, sec. 3, effective July 15, 1998. -- Amended 1992 Ky. Acts ch. 211, sec. 44, effective July 14, 1992; and ch. 445, sec. 5, effective July 14, 1992. -- Amended 1982 Ky. Acts ch. 344, sec. 21, effective July 15, 1982. -- Amended 1974 Ky. Acts ch. 74, Art. V, sec. 24(14). -- Amended 1966 Ky. Acts ch. 255 sec. 188. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 216c-4.

Department of Corrections - 501 KAR 3:090. Medical services.
www.lrc.ky.gov/kar/501/003/090.htm

RELATES TO: KRS 72.025, 441.045, 441.047, 441.055, 441.560
STATUTORY AUTHORITY: KRS 196.035, 197.020, 441.055, 441.560
NECESSITY, FUNCTION, AND CONFORMITY: KRS 441.055 requires the Department of Corrections to promulgate administrative regulations establishing minimum health standards for jails that house state prisoners. This administrative regulation establishes procedures for the proper delivery of medical services in full-service jails.

Section 1. Medical Services.

(1) The jail's medical services shall be provided by contracting with a health care provider licensed in Kentucky.
(2) The medical authority shall be a licensed practical nurse (LPN), a higher level of licensed nurse, a licensed medical doctor, or licensed doctor of osteopathy. Telehealth services may be used, except for mental health evaluations for involuntary commitments pursuant to KRS Chapter 202A.
(3) The health care staff shall not be restricted by the jailer in their performance of their duties except to adhere to the jail's security requirements.
(4) All health care staff working in the jail shall comply with state licensure and certificate requirements commensurate with similar health care personnel working elsewhere in the community. Copies of licenses and certificates for health care staff employed by the jail shall be maintained on file within the jail.
(5) A daily medical log shall be maintained documenting specific medical treatment rendered in the jail. This log shall be kept current to the preceding hour.
(6) Prisoners shall not perform any medical functions within the jail.
(7) Prisoners shall be informed verbally and in writing at the time of admission the methods of gaining access to medical care within the jail.
(8) All medical procedures shall be performed according to orders issued by the responsible medical authority. All medical procedures that require hospital care shall use the Kentucky Correctional Health Care Services Network, or other contracted health care network.
(9) Medical screening shall be performed by the receiving jail personnel on all prisoners upon their admission to the jail and before their placement in prisoner living areas. The findings of this medical screening shall be recorded on a printed screening form approved by the medical authority. The medical screening inquiry shall include:
    (a) Current illnesses and health problems;
    (b) Medications taken and special health requirements;
    (c) Screening of other health problems designated by the medical authority;
    (d) Behavioral observation, state of consciousness, and mental status;
    (e) Notation of body deformities, markings, bruises, lesions, jaundice, ease of movement, and other distinguishing characteristics;
    (f) Condition of skin and body orifices, including rashes and infestations; and
    (g) Disposition and referral of prisoners to qualified medical personnel on an emergency basis.

(10) Sick call conducted by the medical authority shall be available to each prisoner as provided by this subsection.
  (a) Category I jails shall hold sick call two (2) days per week, at a minimum.
  (b) Category II jails shall hold sick call three (3) days per week, at a minimum.
  (c) Category III jails shall hold sick call four (4) days per week, at a minimum.
  (d) Category IV jails shall hold sick call five (5) days per week, at a minimum.
  (e) Category V jails shall hold sick call six (6) days per week, at a minimum.

(11) Jailers, jail administrators, or jail personnel shall report suicides or attempted suicides that constitute a serious health situation to the department within twenty-four (24) hours.

(12) Each jail shall have a written policy and procedure outlining jail personnel response to detainees who are at risk for suicide or have attempted or completed suicide.

(13) Emergency medical, vision, and dental care shall be available to all prisoners commensurate with the level of care available to the community.

(14) Medical research shall not be permitted on any prisoner in the jail.

(15) Access to the prisoner's medical file shall be controlled by the medical authority and the jailer. The medical record shall be separate from custody and other administrative records of the jail.

(16) The jail shall follow informed consent standards in the community for prisoner care.

(17) The jailer, jail administrator, or jail personnel shall notify the coroner, if a prisoner dies while in the jail's custody, to allow for a postmortem examination pursuant to KRS 72.025.

(18) The jailer or jail administrator shall have written delousing procedures.

(19) The jail shall have first aid kits available at all times.

(20) A prisoner who has been prescribed treatment by a recognized medical authority and cannot receive that treatment in the jail shall be moved to another confinement facility that can provide the treatment or may be moved to a hospital.

(21) If emergency care is needed, it shall be provided.

Section 2. Medical Transfers Pursuant to KRS 441.560.

(1) A jailer, jail administrator, or jail personnel may request that a prisoner be transferred to the department for necessary medical treatment and care if the prisoner:
  (a) Is injured;
  (b) Is pregnant;
  (c) Becomes sick or ill;
  (d) 1. Is severely and persistently mentally ill; and
    2. Is presenting an imminent risk of harm to self or others; or
  (e) Requires specialized medical care or long-term medical care that is not available at the local jail.

(2) The transfer request shall be submitted to the Classification Branch in writing and shall contain the following information:
  (a) Prisoner's name;
  (b) Prisoner's Social Security number;
  (c) County where currently housed;
  (d) Inmate number;
  (e) Pending charge or conviction and whether felony or misdemeanor;

(f) Estimated sentence or time to serve;
(g) Whether the prisoner has insurance or not;
(h) Whether the prisoner is indigent or not;
(i) Justification for medical transfer;
(j) Whether the care is necessary or not;
(k) Any conflict reports; and
(l) Relevant attachments such as:
1. Copy of prisoner's insurance card;
2. Doctor's report;
3. Incident report;
4. Citation;
5. Booking information;
6. Preexisting medical records; or
7. Current medication.

(3) If a prisoner is approved for transfer to the department, pursuant to KRS 441.560, the jail shall provide the following, unless already provided with the transfer request:
(a) All medical information;
(b) Current medication in proper container;
(c) Booking information;
(d) Incident reports;
(e) Current citation;
(f) Classification information;
(g) Conflict reports;
(h) Any additional pertinent information; and
(i) Custody receipt.

(4) If a prisoner is approved for transfer to the department, pursuant to KRS 441.560, the prisoner shall be transported by the department.

Section 3. Inmate Medications.
When a prisoner is transferred from the jail to another facility, or discharged:

(1) A copy of the most recent Medical Administration Record (MAR) shall be sent with the prisoner; and

(2) If prescribed medication was purchased for a prisoner, by the jail, then the jail may provide the medication, a prescription, or both to the prisoner. (9 Ky.R. 644; Am. 927; eff. 3-2-1983; 13 Ky.R. 688; eff. 11-11-86; 19 Ky.R. 1852; eff. 6-7-1993; 29 Ky.R. 2758; 30 Ky.R. 23; eff. 7-17-2003; 31 Ky.R. 1557; 1796; eff. 5-26-2005; 34 Ky.R. 1184; 1964; eff. 3-7-2008; 37 Ky.R. 2954; 38 Ky.R. 574; 755; eff. 11-4-2011; 42 Ky.R 1950; 2343; **eff. 3-4-2016.)**

Department of Corrections - 501 KAR 7:090. Medical services.

www.lrc.ky.gov/kar/501/007/090.htm

RELATES TO: KRS 72.025, 441.045, 441.055, 441.560
STATUTORY AUTHORITY: KRS 441.055, 441.560
NECESSITY, FUNCTION, AND CONFORMITY: KRS 441.055 requires the Department of Corrections to promulgate administrative regulations establishing minimum standards for jails that house state prisoners. This administrative regulation establishes procedures to provide proper medical services in restricted custody centers.

Section 1. Medical Services.

(1) The center's medical services shall be provided by contracting with a Kentucky licensed health care provider.
(2) The medical authority shall be a licensed practical nurse (LPN), a higher level of licensed nurse, a licensed medical doctor, or licensed doctor of osteopathy. Telehealth services may be used.
(3) The health care staff and mental health professionals shall not be restricted by the jailer in the performance of their duties except to adhere to the center's security requirements.
(4) All health care staff working in the center shall comply with state licensure and certificate requirements commensurate with similar health care personnel working elsewhere in the community. Copies of the licenses and certificates for health care staff employed by the center shall be maintained on file within the center.
(5) A daily medical log shall be maintained documenting specific medical treatment rendered in the center. This log shall be kept current to the preceding hour.
(6) Prisoners shall not perform any medical functions within the center.
(7) Prisoners shall be informed verbally and in writing at the time of admission the methods of gaining access to medical care within the center.
(8) All medical procedures shall be performed according to orders issued by the responsible medical authority.
(9) Medical screening information shall be transferred to the center from the jail on each prisoner. Jail personnel shall ensure that the information is current when the prisoner is transferred. The medical screening inquiry shall include but not be limited to:
    (a) Current illnesses and health problems;
    (b) Medications taken and special health requirements;
    (c) Screening of other health problems designated by the medical authority;
    (d) Behavioral observation, state of consciousness, and mental status;
    (e) Notation of body deformities, markings, bruises, lesions, jaundice, ease of movement, and other distinguishing characteristics;
    (f) Condition of skin and body orifices, including rashes and infestations; and
    (g) Disposition and referral of prisoners to qualified medical personnel on an emergency basis.
(10) Medical, dental, and psychological care for prisoners shall be provided in accordance with KRS Chapter 441.
(11) Medical research shall not be permitted on any prisoner in the center.
(12) Access to the prisoner’s medical file shall be controlled by the medical authority and the jailer. The medical record shall be separate from custody and other administrative records of the center.
(13) The jailer or designee shall notify the coroner, if a prisoner dies while in the jail’s custody, to allow for a postmortem examination pursuant to KRS 72.025.

(14) The center shall have first aid kits available at all times.
(15) If a urine surveillance program is in effect there shall be written procedures for carrying out the program

Section 2. Medical Transfers pursuant to KRS 441.560.

(1) A jailer may request that a prisoner be transferred to the department for necessary medical treatment and care if the prisoner:
  (a) Is injured;
  (b) Is pregnant;
  (c) Becomes sick or ill;
  (d) 1. Is severely and persistently mentally ill; and
    2. Is presenting an imminent risk of harm to self or others; or
  (e) Requires specialized medical care or long-term medical care which is not available at the local jail.

(2) The transfer request shall be submitted to the Classification Branch in writing and shall contain the following information:
  (a) Prisoner's name;
  (b) Prisoner's Social Security number;
  (c) County where currently housed;
  (d) Inmate number;
  (e) Pending charge or conviction and whether felony or misdemeanor;
  (f) Estimated sentence or time to serve;
  (g) Whether the prisoner has insurance or not;
  (h) Whether the prisoner is indigent or not;
  (i) Justification for medical transfer;
  (k) Whether the care is necessary or not;
  (l) Any conflict reports; and
  (m) Relevant attachments such as:
    1. Copy of prisoner's insurance card;
    2. Doctor's report;
    3. Incident report;
    4. Citation;
    5. Booking information;
    6. Preexisting medical records; or
    7. Current medication.

(3) If a prisoner is approved for transfer to the department, pursuant to KRS 441.560, the jail shall provide the following, unless already provided with the transfer request:
  (a) All medical information;
  (b) Current medication in proper container;
  (c) Booking information;
  (d) Incident reports;
  (e) Current citation;
  (f) Classification information;

(g) Conflict reports;
(h) Any additional pertinent information; and
(i) Custody receipt.

(4) If a prisoner is approved for transfer to the department pursuant to KRS 441.560, the prisoner shall be transported by the department. (13 Ky.R. 824; eff. 11-11-86; 31 Ky.R. 1731; 1965; eff. 7-1-2005; 34 Ky.R. 1195; 1972; eff. 3-7-2008; 37 Ky.R. 2982; 38 Ky.R. 588; **eff. 10-7-11**.)

Department of Corrections - 501 KAR 7:010. Definitions for 501 KAR Chapter 7.
www.lrc.ky.gov/kar/501/007/010.htm

RELATES TO: KRS 67.900, 67A.028, 67B.020(1), 441.045, 441.055, Ky. Const. Sec. 99, 152
STATUTORY AUTHORITY: KRS 441.055
NECESSITY, FUNCTION, AND CONFOMITY: KRS 441.055(1) requires the Department of Corrections to promulgate administrative regulations establishing minimum standards for jails that house state prisoners. This administrative regulation establishes definitions for 501 KAR Chapter 7, regulating restricted custody centers.

Section 1. Definitions.

(1) "Automatic fire extinguishing system" means an approved system of devices and equipment that automatically detects a fire and discharges an approved fire extinguishing agent onto or in the area of a fire in accordance with 815 KAR 7:120.
(2) "Department" is defined by KRS 441.005(5).
(3) "Governing authority" means a county fiscal court, urban-county government, charter county government, consolidated local government, unified local government, or regional jail authority.
(4) "Jail administrator" means the official appointed by a regional jail authority and charged with the responsibility of administering the regional jail.
(5) "Jailer" means:
(a) The official duly elected or appointed pursuant to Section 99 or 152 of the Kentucky Constitution, charged with the responsibility of administering the center;
(b) A department as defined by KRS 67B.020(1);
(c) A correctional services division as created by KRS 67A.028; or
(d) Jail administrator.
(6) "Jail personnel" is defined by KRS 441.005(6).
(7) "Medical authority" means the person or persons licensed to provide medical care to prisoners in the jail's custody.
(8) "Pat" or "frisk" means a manual search of a clothed person and includes a visual inspection of the open mouth.
(9) "Prisoner" is defined by KRS 441.005(3).
(10) "Prisoner living area" means a group of rooms or cells which provide housing for the prisoner population.
(11) "Probing of body cavities" means a manual or instrument search of a person's oral, anal, vaginal, or other body cavity, performed by medical personnel.

(12) "Restricted custody center" or "center" means a facility or area separate from the jail used for the housing of:
  (a) Sentenced prisoners who have been approved for educational, work, or program participation release; and
  (b) Pretrial prisoners who have been approved by the court for educational, work, or program participation release.
(13) "Security area" means a defined space whose physical boundaries have controlled ingress and egress.
(14) "Sexually abusive conduct" means:
  (a) Sexual conduct, sexual intercourse, and deviate sexual intercourse, as defined by KRS 510.010;
  (b) Sexual abuse as defined by 28 C.F.R. 115.6; and
  (c) Other types of similar sexually based conduct.
(15) "Strip search" means a body search during which a person is required to open or remove clothing, and during which a person is subject to visual inspection of the torso, female breast, genital area, and anal area, as well as other body cavities.
(16) "Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, transfer of health or medical data, and continuing education. (13 Ky.R. 815; eff. 11-11-1986; Am. 22 Ky.R. 1359; 1599; eff. 3-7-1996; 26 KyR. 174; 27 Ky.R. 87; eff. 7-17-2000; 31 Ky.R. 1729; eff. 7-1-2005; 2969; 38 Ky.R. 583; eff. 10-7-2011; 42 Ky.R. 1957; 2347; **eff. 3-4-2016**).

Department of Corrections - 501 KAR 13:010. Life safety issues.
www.lrc.ky.gov/kar/501/013/010.htm

RELATES TO: KRS 67.900, 198B.650-198B.689, 217.280-217.390, 441.005, 441.045, 441.055, 441.560, 532.100

STATUTORY AUTHORITY: KRS 196.035, 197.020, 441.055, 441.560

NECESSITY, FUNCTION, AND CONFORMITY: KRS 441.055 requires the Department of Corrections to promulgate administrative regulations establishing minimum health and life safety standards for jails that do not house state prisoners. This administrative regulation sets forth procedures to provide protection for basic health and life safety in jails that do not house state prisoners.

Section 1. Definitions.
(1) "Department" is defined by KRS 441.005(5).
(2) "Governing authority" means a county fiscal court, urban-county government, charter county government, consolidated local government, unified local government, or regional jail authority.
(3) "Jail" or "Life Safety Jail" means any county jail and correctional or detention facility, including correctional facilities defined by KRS 67B.020, operated by and under the supervision of a governing authority that does not house state prisoners pursuant to KRS 532.100.
(4) "Jail personnel" is defined by KRS 441.005(6).

(5) "Medical authority" means the person or persons licensed to provide medical care to prisoners in the jail's custody.
(6) "Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, transfer of health or medical data, and continuing education.

Section 2. Policy and Procedure.
The jailer shall develop and maintain a policy and procedures manual that has been adopted by the governing authority and filed with the department. The policy and procedures manual shall include, at a minimum, the following aspects of the jail's operation:
(1) Administration;
(2) Staffing;
(3) Security and control;
(4) Physical plant;
(5) Fire safety;
(6) Sanitation and hygiene;
(7) Medical services; and
(8) Food services.

Section 3. Administration.
(1) Jail information and prisoner records shall be stored in a secure manner so that they are protected from theft, loss, tampering, and destruction. Prisoner records shall be maintained as required by the Department of Libraries and Archives pursuant to 725 KAR Chapter 1.
(2) A telephonic report to the department shall be made of all extraordinary or unusual occurrences within twenty-four (24) hours of the occurrence, and a final written report shall be made within forty-eight (48) hours. This report shall be placed in the jail record. Extraordinary or unusual occurrences shall include:
    (a) Death of a prisoner;
    (b) Suicide or attempted suicide that constitutes a serious health concern;
    (c) Serious injury, whether accidental or self-inflicted;
    (d) Escape or attempted escape from confinement;
    (e) Fire;
    (f) Riot;
    (g) Assault, whether by jail personnel or prisoner;
    (h) Sexually abusive conduct;
    (i) Occurrence of contagious or infectious disease, or illness within the facility; and
    (j) Any serious event that threatens the safety or security of the facility or jail personnel.
(3) The jail shall, if there is an escape, immediately:
    (a) Notify the Division of Local Facilities jail inspector;
    (b) Notify Kentucky State Police or local law enforcement;
    (c) Activate VINE through use of the Emergency Override Line (EOL); and
    (d) Enter the prisoner's escape status into the jail management system.

Section 4. Staffing.

(1) Each jail shall provide twenty-four (24) hour awake supervision for all prisoners by providing a minimum of two (2) jail personnel, excluding jail personnel designated for communication. If requested by the jailer or governing authority, the department may conduct a staffing analysis.
(2) Each jail shall be required to provide the Department with a weekly population update.
(3) If a female prisoner is lodged in the jail, the jail shall provide a female deputy to perform twenty-four (24) hour awake supervision.
(4) Qualifications. Jail personnel shall be at least twenty-one (21) years of age.
(5) Compensation. Each employee shall receive a wage at least equal to the State Minimum Wage Law except if Federal Minimum Wage Law applies.
(6) Males and females shall be housed separately.

Section 5. Security and Control.

(1) Jail personnel shall conduct and document direct, in-person surveillance of each prisoner on an irregular basis, at least every sixty (60) minutes.
(2) Jail personnel shall conduct and document direct, in-person surveillance every twenty (20) minutes, at irregular intervals, on the following classes of prisoners:
    (a) Suicidal; and
    (b) Mentally or emotionally disturbed.
(3) There shall be at least three (3) documented prisoner counts every twenty-four (24) hours during which each prisoner's physical presence, by show of skin or by movement, shall be observed. At least one (1) count shall be conducted per shift.
(4) A prisoner shall not be assigned to a position of authority over another prisoner.
(5) A prisoner shall not be permitted to perform or assist in a security duty.
(6) A trustee, if used, shall not have access to or control of a weapon.
(7) Daily Jail Log; Special reports. A daily log shall be kept current and shall reflect significant occurrences within the jail. Special reports shall include:
    (a) Disciplinary action;
    (b) Medical or mental health treatment;
    (c) Feeding schedule and menus;
    (d) Extraordinary occurrences:
        1. Fire;
        2. Assault;
        3. Suicide or attempted suicide; or
        4. Escape or attempted escape;
    (e) Inmate vandalism:
        1. Destruction of jail property; or
        2. Flooding of plumbing fixtures;
    (f) Jail personnel roster for each shift; and
    (g) Visitor's log.

Section 6. Physical Plant.

(1) Square footage living space requirement for jails shall be the same as required in 501 KAR 3:050.

(2) All furnishings in the jail shall be noncombustible and nontoxic as approved by the department.
(3) Kitchen. The purpose of this area shall be to provide sufficient space and equipment for preparing meals for the maximum rated capacity of the jail. Design features shall include:
  (a) Compliance with standards of the Kentucky Food Code, 902 KAR 45:005;
  (b) Commercial type stoves and refrigeration units; and
  (c) Walls, floors, and decks that are approved fire-rated masonry, concrete, or steel construction.
(4) Gauges, indicators, and alarms shall be located in an area monitored by jail personnel.
(5) The jail shall provide ventilation to meet the air exchange requirements in the Kentucky Department of Corrections Jail Construction, Expansion, and Renovation Guidelines incorporated by reference in 501 KAR 3:050.
(6) Electrical outlets if provided shall be ground-faulted or have ground-fault circuit breakers.
(7) All tools, toxic, corrosive, and flammable substances, and other potentially dangerous supplies and equipment shall be stored in a locked area not accessible to prisoners.
(8) The jail shall have a procedure for immediate reporting and repairing any broken or malfunctioning key or lock.
(9) A set of duplicate keys shall be maintained in a separate, secure place.
(10) Each jail shall comply with the Kentucky Building Code, 815 KAR 7:120.

Section 7. Fire Safety.
(1) Each jail shall have a written policy and procedure that specifies fire prevention practices to ensure the safety of prisoners, visitors, and jail personnel. These shall include, at a minimum:
  (a) Fire emergency planning sessions for jail personnel at least quarterly;
  (b) Maintaining written documentation of fire planning sessions and a written copy of the material taught;
  (c) A fire safety inspection by the department at least once a year;
  (d) Inspection and testing of fire protection equipment by qualified persons at least annually with visual inspections by jail personnel monthly;
  (e) Being a tobacco-free facility; and
  (f) A written evacuation plan coordinated with local fire officials.
(2) Each jail shall have exits distinctly and permanently marked, visible at all times, kept clear, and maintained in usable condition.
(3) Each jail shall have equipment necessary to maintain essential lights, power, HVAC, and communications in an emergency situation.
(4) In each area where a prisoner may be confined, there shall be an emergency smoke control system activated by smoke detectors and operated by emergency power. Inspection and testing of the smoke control system shall be conducted by a qualified person at least annually.
(5) Each jail shall have an approved fire alarm and smoke detection system.

Section 8. Sanitation; Hygiene.
(1) The jailer shall provide for the control of vermin and pests.
(2) The jail shall provide for both solid and liquid waste disposal.
(3) The jail shall have fresh air circulating within prisoner living and activity areas.
(4) All prisoners shall be provided with hot and cold running water in showers and lavatories.

(5) All prisoners shall be provided with toilet paper or feminine hygiene items when needed.

Section 9. Medical Services.

(1) Jail personnel shall have current training in standard first aid equivalent to that provided by the American Red Cross, the American Heart Association, or an equivalent nationally recognized organization. New jail personnel shall receive training within their first year of employment.

(2) At least one (1) jail personnel on site shall be certified to perform CPR (Cardiopulmonary Resuscitation), equivalent to that provided by the American Red Cross, the American Heart Association, or an equivalent nationally recognized organization. New jail personnel shall receive certification within their first year of employment.

(3) The jail shall have first aid kits available at all times.

(4) Medical screening shall be performed by the receiving jail personnel on all prisoners upon their admission to the jail and before their placement in prisoner living areas. The findings of this medical screening shall be recorded on a printed screening form approved by the medical authority. The medical screening inquiry shall include:
   (a) Current illnesses and health problems;
   (b) Medications taken and special health requirements;
   (c) Screening of other health problems designated by the medical authority;
   (d) Behavioral observation, state of consciousness, and mental status;
   (e) Notation of body deformities, markings, bruises, lesions, jaundice, ease of movement, and other distinguishing characteristics;
   (f) Condition of skin and body orifices, including rashes and infestations; and
   (g) Disposition and referral of prisoners to qualified medical personnel on an emergency basis.

(5) Each prisoner shall be afforded access to necessary medical care as in KRS 441.045.

(6) The medical authority shall be a licensed practical nurse (LPN), a higher level of licensed nurse, a licensed medical doctor, or licensed doctor of osteopathy. Telehealth services may be used.

Section 10. Medical Transfers pursuant to KRS 441.560.

(1) A jailer may request that a prisoner be transferred to the department for necessary medical treatment and care if the prisoner:
   (a) Is injured;
   (b) Is pregnant;
   (c) Becomes sick or ill;
   (d) 1. Is severely and persistently mentally ill; and
       2. Is presenting an imminent risk of harm to self or others; or
   (e) Requires specialized medical care or long-term medical care which is not available at the local jail.

(2) The transfer request shall be submitted to the Classification Brach in writing and shall contain the following information:
   (a) Prisoner's name;
   (b) Prisoner's Social Security number;
   (c) County where currently housed;
   (d) Inmate number;

(e) Pending charge or conviction and whether felony or misdemeanor;
(f) Estimated sentence or time to serve;
(g) Whether the prisoner has insurance or not;
(h) Whether the prisoner is indigent or not;
(i) Justification for medical transfer;
(j) Whether the care is necessary or not;
(k) Any conflict reports; and
(l) Relevant attachments such as:
1. Copy of prisoner's insurance card;
2. Doctor's report;
3. Incident report;
4. Citation;
5. Booking information;
6. Preexisting medical records; or
7. Current medication.

(3) If a prisoner is approved for transfer to the department as a medical prisoner, the jail shall provide the following, unless already provided with the transfer request:
(a) All medical information;
(b) Current medication in proper container;
(c) Booking information;
(d) Incident reports;
(e) Current citation;
(f) Classification information;
(g) Conflict reports;
(h) Any additional pertinent information; and
(i) Custody receipt.

(4) If a prisoner is approved for transfer to the department as a medical prisoner, the prisoner shall be transported by the department.

Section 11. Food Services.

(1) The jail shall comply with KRS 217.280 to 217.390, 803 KAR 2:317, and 902 KAR 45:005.
(2) The jail shall provide prisoners with a nutritionally adequate diet containing at least 2,400 calories daily and jail menus shall be approved annually by a nutritionist or dietician. Condiments shall not be included in the daily caloric totals.
(3) Except as provided by subsection (4) of this section, prisoners shall receive three (3) meals per day, one (1) of which shall be hot. More than fourteen (14) hours shall not elapse between any two (2) meals.
(4) The jailer may elect to provide only two (2) meals on Saturdays, Sundays, and holidays, if both meals still meet the minimum 2,400 calories per day. Condiments shall not be included in the daily caloric totals. If the jailer elects to serve only two (2) meals, more than sixteen (16) hours shall not elapse between any two (2) meals.
(5) The jailer shall provide for medical diets if prescribed by a medical authority.
(6) The jailer shall maintain accurate records of all meals served.

(7) Food shall not be used for disciplinary purposes.
(8) Jail personnel shall directly supervise all food prepared within the jail.
(9) All food shall be served under the direct supervision of jail personnel.
(10) The jail shall have sufficient cold and dry food storage facilities.
(11) The jailer or his designee shall inspect the food service area daily.
(12) Canteen food items purchased by prisoners may be stored and prepared in amounts that do not pose a threat to the health or security of the institution (22 Ky.R. 1402; Am. 1601; eff. 3-7-1996; 24 Ky.R. 1418; eff. 4-15-1998; 29 Ky.R. 2770; 30 Ky.R. 31; eff. 7-17-2003; 31 Ky.R. 1580; 1810; eff. 5-26-2005; 34 Ky.R. 1200; 1721; eff. 3-7-2008; eff. 9-5-2008; 37 Ky.R. 2992; 38 Ky.R. 592; eff. 10-7-2011; 42 Ky.R. 1969; 2352; eff. **3-4-2016**.)

KENTUCKY BOARD OF DENTISTRY

KRS 313.010. Definitions for chapter. www.lrc.ky.gov/Statutes/statute.aspx?id=30806

As used in this chapter, unless the context requires otherwise:
(1) "Board" means the Kentucky Board of Dentistry;
(2) "Certified dental technician" means an individual recognized as such by the National Board for Certification in Dental Laboratory Technology;
(3) "Delegated duties list" means the list of procedures authorized in administrative regulation which may be delegated by a dentist licensed under this chapter to a licensed dental hygienist or a registered dental assistant;
(4) "Dental auxiliary personnel" means any staff member of a dental office not licensed by or registered with the board;
(5) "Dental hygiene" means the treatment of the oral cavity, including but not limited to dental hygiene assessment or screening, scaling and root planing, nonsurgical therapy, removing calcareous deposits, removing accumulated accretion from beneath the free gingival margin, cavity preventive procedures, periodontal procedures that require administering antimicrobial agents along with other general dentistry activities outlined in the treatment care plan and not prohibited by this chapter or by administrative regulation promulgated by the board;
(6) "Dental hygienist" means any person who has graduated from a CODA accredited dental hygiene program at an institute of higher learning and has been credentialed as a "Registered Dental Hygienist";
(7) "Dental laboratory" includes any person, firm, or corporation other than a licensed dentist, who directly or through an agent or employee, by any means or method, in any way supplies or manufactures artificial substitutes for the natural teeth, other than those unfinished substitutes normally available through dental supply houses, or who furnishes supplies, constructs, or reproduces or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth or who performs or offers or undertakes to perform or accomplish dental laboratory technology;

(8) "Dental laboratory technician" means any person who performs or offers or undertakes to perform or accomplish dental laboratory technology;

(9) "Dental specialist" means a dentist who practices in fields of specialty recognized and approved by the American Dental Association;

(10) "Dentist" means any person who has graduated from a Commission on Dental Accreditation (CODA) accredited dental school and has been conferred with the degree of "Doctor of Medical Dentistry" (D.M.D.) or "Doctor of Dental Surgery" (D.D.S.);

(11) "Dentistry" means the evaluation, diagnosis, prevention, or surgical, nonsurgical, or related treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial area, or the adjacent and associated structures and their impact on the human body provided by a dentist within the scope of his or her education, training, and experience and in accordance with the ethics of the profession and applicable law. Any person shall be regarded as "practicing dentistry" who, for a fee, salary, or other reward paid, or to be paid either to himself or herself, or to another person, performs or advertises to perform, dental operations of any kind, including the whitening of natural or manufactured teeth, or who diagnoses or treats diseases or lesions of human teeth or jaws, or attempts to correct malpositions thereof, or who diagnoses or treats disorders, or deficiencies of the oral cavity and adjacent associated structures, or who takes impressions of the human teeth or jaws to be used directly in the fabrication of any intraoral appliance, or shall construct, supply, reproduce or repair any prosthetic denture, bridge, artificial restoration, appliance or other structure to be used or worn as a substitute for natural teeth, except upon the written laboratory procedure work order of a licensed dentist and constructed upon or by the use of casts or models made from an impression taken by a licensed dentist, or who shall advertise, offer, sell, or deliver any such substitute or the services rendered in the construction, reproduction, supply, or repair thereof to any person other than a licensed dentist, or who places or adjusts such substitute in the oral cavity of another, or who uses the words "dentist," "dental surgeon," the letters "D.D.S.," "D.M.D.," or other letters or title in connection with his or her name, which in any way represents him or her as being engaged in the practice of dentistry;

(12) "Direct supervision" means that the dentist is physically present in the dental office or treatment facility, personally diagnoses the condition to be treated, authorizes the procedures to be performed, remains in the dental office or treatment facility while the procedures are being performed, and evaluates the performance of the individual supervised;

(13) "General supervision" means a circumstance of treatment in which a dentist licensed under this chapter must diagnose and authorize the work to be performed on a patient by the dental hygienist authorized pursuant to administrative regulation to work under general supervision but the dentist is not required to be on the premises while the treatment is carried out;

(14) "Registered dental assistant" means any person who is registered with the board and works under the direct supervision of a dentist;

(15) "Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education; and

(16) "Volunteer community health setting" means a setting in which services are rendered at no charge to the patient or to third-party payors.

Effective: **July 15, 2010**

History: Repealed and reenacted 2010 Ky. Acts ch. 85, sec. 1, effective July 15, 2010. -- Amended 2009 Ky. Acts ch. 55, sec. 1, effective June 25, 2009. -- Amended 1978 Ky. Acts ch. 155, sec. 162, effective June 17, 1978. -- Amended 1974 Ky. Acts ch. 303, sec. 1. -- Amended 1970 Ky. Acts ch. 75. sec. 1. -- Amended 1964 Ky. Acts ch. 12, sec. 1. -- Amended 1950 Ky. Acts ch. 139, sec. 1. -- Amended 1948 Ky. Acts ch. 6, sec. 1. -- Created 1942 Ky. Acts ch. 60, sec. 1. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. secs. 2636-11, 2636-18.
Legislative Research Commission Note (7/15/2010). Under the authority of KRS 7.136(1), the Reviser of Statutes has changed the internal numbering of this statute to place definitions in alphabetical order. No words were changed in this process.

Kentucky Board of Dentistry - KRS 313.060. Administrative regulations governing minimal requirements for documentation, oath for disease control compliance, sedation of patients, and compliance with federal statutes and regulations -- Death or incapacity of dentist -- Telehealth -- Continuing education. www.lrc.ky.gov/Statutes/statute.aspx?id=30815

(1) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A relating to dental practices which shall include minimal requirements for documentation, Centers for Disease Control compliance, conscious sedation of patients, compliance with federal controlled substances regulations, and any applicable federal statute or regulation.
(2) Any person practicing or offering to practice dentistry or dental surgery shall practice under his or her own name or the name of a deceased or incapacitated dentist for whom the person practicing dentistry has contracted to perform continuing operations.
(3) No person shall conduct a dental office in his or her name nor advertise his or her name in connection with any dental office unless he or she personally performs services as a dentist or dental surgeon in such office or personally supervises such services as are performed in such office during a portion of the time such office is operated by him or her only, and shall not use his or her name in connection with that of any other dentist, except as provided for deceased or incapacitated dentists in subsection (4) of this section.
(4) The executor or administrator of a deceased dentist's estate, or the legal guardian or authorized representative of a dentist who has become incapacitated, may contract with another dentist or dentists to continue the operations of the deceased or incapacitated dentist's practice if the practice of the deceased or incapacitated dentist is a:
    (a) Sole proprietorship;
    (b) Corporation in which the deceased or incapacitated dentist is the sole shareholder; or
    (c) Limited liability company in which the deceased or incapacitated dentist is the sole member.
(5) Contracts to continue the operations of a deceased or incapacitated dentist's practice may extend until the practice is sold.
(6) Prior to contracting with another dentist or dentists to continue operations of a deceased or incapacitated dentist's practice, the executor, administrator, guardian, or authorized representative shall file a notification of intent to contract for continuation of practice with the board on a form prescribed by the board. The notification shall include the following information:

(a) The name and license number of the deceased or incapacitated dentist;
(b) The name and address of the dental practice;
(c) The name, address, and tax identification number of the estate;
(d) The name and license number of each dentist who will provide services in the dental practice;
(e) An affirmation, under penalty of perjury, that the information provided is true and correct and that the executor, administrator, guardian, or authorized representative understands that any interference by the executor, administrator, guardian, or authorized representative, or any agent or assignee of the executor, administrator, guardian, or authorized representative, with the contracting dentist's or dentists' practice of dentistry or professional judgment or any other violation of this chapter is grounds for an immediate termination of the operations of the dental practice; and
(f) Any other information the board deems necessary for the administration of this chapter.

(7) Within thirty (30) days after the death or incapacitation of a dentist, the executor, administrator, guardian, or authorized representative shall send notification of the death or incapacitation by mail to the last known address of each patient of record that has received treatment by the deceased or incapacitated dentist within the previous twelve (12) months, with an explanation of how copies of the practitioner's records may be obtained. This notice may also contain any other relevant information concerning the continuation of dental practice.

(8) A treating dentist who provides or facilitates the use of telehealth shall ensure:
(a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
(b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(9) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
(a) Prevent abuse and fraud through the use of telehealth services;
(b) Prevent fee-splitting through the use of telehealth services; and
(c) Utilize telehealth in the provision of dental services and in the provision of continuing education.

(10) A licensed dentist may delegate to a licensed dental hygienist the administration of block and infiltration anesthesia and nitrous oxide analgesia under the direct supervision of a dentist if the dental hygienist completes the following requirements and receives a certificate of verification from the board:
(a) Formal training from a dental or dental hygiene school accredited by the Commission on Dental Accreditation;
(b) A minimum of thirty-two (32) hours covering all of the following topics, including but not limited to anatomical considerations, basic injunction technique, basic placement technique, nitrous oxide administration, recordkeeping, armamentarium exercise, local anesthesia and nitrous oxide, techniques of maxillary anesthesia, techniques of mandibular injections, partner injections and partner administration of nitrous oxide, neurophysiology,

pharmacology of local anesthetics and nitrous oxide, pharmacology of vasoconstrictors, physical and psychological evaluation, local and systemic complications, and contraindications;

(c) A minimum of two (2) hours of clinical education for nitrous oxide administration with successful completion of administration, monitoring, and removal of nitrous oxide on at least two (2) patients;

(d) A minimum of twelve (12) hours demonstrating mastery of local anesthesia applications and successful completion of at least three (3) injections each of all maxillary and mandibular injection sites; and

(e) A score that exceeds seventy-four percent (74%) on a written examination administered after coursework and clinical training.

(11) The board shall approve all continuing education courses and require them for individuals holding anesthesia registration for over one (1) year without practical application. The courses shall be developed and implemented by dental education institutions accredited by the Commission on Dental Accreditation.

Effective: July 15, 2010

History: Repealed and reenacted 2010 Ky. Acts ch. 85, sec. 10, effective July 15, 2010. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 2636-10.

KENTUCKY BOARD OF LICENSURE AND CERTIFICATION FOR DIETITIANS AND NUTRITIONISTS

KRS 310.200. Duty of treating dietitian or nutritionist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=30392

(1) A treating dietitian or nutritionist who provides or facilitates the use of telehealth shall ensure:

(a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and

(b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:

(a) Prevent abuse and fraud through the use of telehealth services;

(b) Prevent fee-splitting through the use of telehealth services; and

(c) Utilize telehealth in the provision of dietitian and nutrition services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000

History: Created 2000 Ky. Acts ch. 376, sec. 10, effective July 14, 2000.

Kentucky Board of Licensure and Certification for Dietitians and Nutritionists - 201 KAR 33:070. Telehealth and telepractice. www.lrc.ky.gov/kar/201/033/070.htm

RELATES TO: KRS 310.070, 310.200

STATUTORY AUTHORITY: KRS 310.200(1), (2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 310.200 requires the Board of Licensure and Certification for Dietitians and Nutritionists to adopt administrative regulations to further the objectives stated therein. This administrative regulation establishes procedures necessary to prevent abuse and fraud through the use of telehealth, prevent fee-splitting through the use of telehealth, and utilize telehealth in the provision of dietitian and nutrition services, and in the provision of continuing education.

Section 1. Definitions.

(1) "Client" means the person receiving the services of the dietitian or nutritionist.

(2) "Educator" means a presenter speaking to a group of individuals on a topic generally without a focus on the specific needs of any particular individual.

(3) "Licensed healthcare professional" means a medical doctor, registered nurse, practical nurse, nurse practitioner, advanced practice registered nurse, physician's assistant, chiropractor, certified diabetes educator, pharmacist, speech-language pathologist, registered dietitian, certified nutritionist, podiatrist, audiologist, or psychologist licensed in the jurisdiction where he or she is physically located.

(4) "Practitioner" means a licensed dietitian or certified nutritionist.

(5) "Telehealth" is defined by KRS 310.200(3).

(6) "Telepractice" means the practice of dietetics or nutrition as defined by KRS 310.005(2) and provided by using communication technology that is two (2) way, interactive, simultaneous audio and video.

Section 2. Client Requirements.

A practitioner-patient relationship shall not commence via telehealth. An initial, in-person meeting for the practitioner and patient who will prospectively utilize telehealth shall occur in order to evaluate if the potential or current client is a candidate to receive services via telehealth. A licensed health care professional may represent the practitioner at the initial, in-person meeting. A practitioner who uses telehealth to deliver dietetics or nutrition services shall, at the initial, in-person meeting with the client:

(1) Make attempts to verify the identity of the client;

(2) Obtain alternative means of contacting the client other than electronically such as by the use of a telephone number or mailing address;
(3) Provide to the client alternative means of contacting the licensee other than electronically such as by the use of a telephone number or mailing address;
(4) Provide contact methods of alternative communication the practitioner shall use for emergency purposes such as an emergency on call telephone number;
(5) Document if the client has the necessary knowledge and skills to benefit from the type of telepractice provided by the licensee; and
(6) Inform the client in writing and document acknowledgement of the risk and limitations of:
    (a) The use of technology in the provision of telepractice;
    (b) The potential breach of confidentiality of information, or inadvertent access of protected health information, due to technology in the provision of telepractice;
    (c) The potential disruption of technology in the use of telepractice;
    (d) When and how the practitioner will respond to routine electronic messages;
    (e) In what circumstances the practitioner will use alternative communications for emergency purposes;
    (f) Who else may have access to client communications with the practitioner;
    (g) How communications shall be directed to a specific licensee;
    (h) How the practitioner stores electronic communications from the client; and
    (i) That the practitioner may elect to discontinue the provision of services through telehealth.

Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records.
A practitioner using telehealth to deliver services or who telepractices shall:
(1) Limit the telepractice to the area of competence in which proficiency has been gained through education, training, and experience;
(2) Maintain current competency in telepractice through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge;
(3) Document the client's presenting problem, purpose, or diagnosis, and include which services were provided by telepractice;
(4) Use secure communications with each client, including encrypted text messages, via e-mail or secure Web sites, and not use personal identifying information in non-secure communications; and
(5) Ensure that confidential communications obtained and stored electronically shall not be recovered and accessed by unauthorized persons when the licensee disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law.
(1) A practitioner using telehealth to deliver dietetics or nutrition services shall comply with Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with a disability.
(2) A person providing dietetic or nutrition services for which an exception to licensure does not apply or who represents himself or herself as a dietitian, licensed dietitian, or certified nutritionist pursuant to KRS 310.070 shall be licensed by the board if:

(a) Services are offered via telehealth; and
(b) These services are provided or the representation is made to a person when he or she is physically located in Kentucky.

(3) A person providing dietetic or nutrition services for which an exception to licensure does not apply or who represents himself or herself as a dietitian, licensed dietitian, or certified nutritionist pursuant to KRS 310.070 shall be licensed by the board if:
(a) Services are offered via telehealth; and
(b) These services are provided or the representation is made from a physical location in Kentucky. This person may be subject to licensure requirements in other states where the services are received by the client.

(4) No provision of this administrative regulation shall restrict the ability of educators to present on topics related to dietetics and nutrition pursuant to KRS 310.070(2)(d).

Section 5. Representation of Services and Code of Conduct
A licensee using telehealth to deliver services or who telepractices shall not:
(1) Engage in false, misleading, or deceptive advertising of telepractice; or
(2) Split fees. (40 Ky.R. 2228; Am. 2423; **eff. 6-6-2014**.)

DEPARTMENT OF INSURANCE

KRS 304.17A-005. Definitions for subtitle. www.lrc.ky.gov/Statutes/statute.aspx?id=45258

As used in this subtitle, unless the context requires otherwise:
(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;
(2) "At the time of enrollment" means:
(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and
(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;
(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;
(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

(5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);
(6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
(7) "COBRA" means any of the following:
  (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;
  (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or
  (c) 42 U.S.C. sec. 300bb;
(8) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:
    1. A group health plan;
    2. Health insurance coverage;
    3. Part A or Part B of Title XVIII of the Social Security Act;
    4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
    5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;
    6. A medical care program of the Indian Health Service or of a tribal organization;
    7. A state health benefits risk pool;
    8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;
    9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
    10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or
    11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program.
  (b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (14) of this section;
(9) "Dependent" means any individual who is or may become eligible for coverage under the terms of an individual or group health benefit plan because of a relationship to a participant;
(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;
(11) "Eligible individual" means an individual:
  (a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that

period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(12) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in subsection (30) of this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in subsection (5) of this section shall be treated as a large group under this subtitle;

(13) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(14) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;
(f) Credit-only insurance;
(g) Coverage for on-site medical clinics;
(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
(i) Limited scope dental or vision benefits;
(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
(k) Such other similar, limited benefits as are specified in administrative regulations;
(l) Coverage only for a specified disease or illness;
(m) Hospital indemnity or other fixed indemnity insurance;
(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;
(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;
(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and
(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(18) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

(19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(20) "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:
(a) Is not an eligible individual;
(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:
1. Waived coverage under KRS 304.17A-210(2); or
2. Did not elect family coverage that was available through the association or group market;
(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or

is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;
2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or
3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(22) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, or limited health service benefit plans;

(23) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS Chapter 315, or home medical equipment and services provider as defined pursuant to KRS 309.402, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;
(f) Advanced practice registered nurses licensed under KRS Chapter 314; and
(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and
2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(25) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(26) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws;

(27) "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

(28) "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the principal purpose of creating a device,

arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(29) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

(30) "Large group" means:
   (a) An employer with fifty-one (51) or more employees;
   (b) An affiliated group with fifty-one (51) or more eligible members; or
   (c) An employer-organized association that is a bona fide association as defined in subsection (5) of this section;

(31) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(32) "Market segment" means the portion of the market covering one (1) of the following:
   (a) Individual;
   (b) Small group;
   (c) Large group; or
   (d) Association;

(33) "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of the employer or members of the organization, or whose beneficiaries may be eligible to receive any benefit as established in Section 3(7) of ERISA;

(34) "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

(35) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(36) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(37) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(38) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(39) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(40) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(41) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty

(50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(42) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members;

(43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) "Telehealth" has the meaning provided in KRS 311.550.

Effective: July 15, 2016

History: Amended 2016 Ky. Acts ch. 103, sec. 17, effective July 15, 2016. -- Amended 2013 Ky. Acts ch. 123, sec. 4, effective June 25, 2013. -- Amended 2012 Ky. Acts ch. 73, sec. 9, effective July 12, 2012. -- Amended 2010 Ky. Acts ch. 24, sec. 1209, effective July 15, 2010; and ch. 85, sec. 46, effective July 15, 2010. -- Amended 2006 Ky. Acts ch. 253, sec. 1, effective July 12, 2006. -- Amended 2005 Ky. Acts ch. 144, sec. 7, effective June 20, 2005. -- Amended 2002 Ky. Acts ch. 351, sec. 1, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 376, sec. 6, effective July 15, 2001; ch. 476, sec. 17, effective July 14, 2000; and ch. 521, sec. 1, effective July 14, 2000. -- Created 1998 Ky. Acts ch. 496, sec. 1, effective April 10, 1998.

Department of Insurance - KRS 304.17A-138. Prohibition against health benefit plan excluding coverage for telehealth -- Benefits subject to deductible, co-payment, or coinsurance -- Payment subject to provider network arrangements – Administrative regulations. www.lrc.ky.gov/Statutes/statute.aspx?id=17373

(1) (a) A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through a face-to-face consultation if the consultation is provided through the telehealth network established under KRS 194A.125. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer.

(b) A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

(2) Benefits for a service provided through telehealth required by this section may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the health benefit plan for the same service provided through a face-to-face consultation.

(3) Payment made under this section may be consistent with any provider network arrangements that have been established for the health benefit plan.

(4) The department shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms and records required to be maintained in conjunction with this section.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1215, effective July 15, 2010. -- Amended 2007 Ky. Acts ch. 24, sec. 28, effective June 26, 2007. -- Created 2000 Ky. Acts ch. 376, sec. 7, effective July 15, 2001.

Department of Insurance - 806 KAR 17:270. Telehealth claim forms and records.

www.lrc.ky.gov/kar/806/017/270.htm

RELATES TO: KRS 304.17A-138
STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-138(4)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) provides that the executive director may promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.17A-138(4) requires that the office promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms and records required to be maintained for telehealth claims.

Section 1. Definitions.
(1) "ADA" means American Dental Association.
(2) "Electronic" or "electronically" is defined by KRS 304.17A-700(7).
(3) "HCFA" means Health Care Financing Administration.
(4) "Health benefit plan" is defined by KRS 304.17A-005(22).
(5) "Health care provider" or "provider" is defined by KRS 304.17A-005(23).
(6) "Health insurer" or "insurer" is defined by KRS 304.17A-005(27).
(7) "Kentucky Uniform Billing Committee (KUBC)" is defined by KRS 304.17A-700(13).
(8) "National Uniform Billing Committee (NUBC)" is defined KRS 304.17A-700(14).
(9) "Telehealth" is defined by KRS 311.550(17).
(10 "UB" means uniform billing.

Section 2. Application.
This administrative regulation shall apply to health benefit plans delivered, issued, or renewed on or after July 15, 2001.

Section 3. Claim Forms.
The following claim forms shall be used for reimbursement of telehealth consultations:
(1) A claim form for dentists shall consist of the ADA Form - J588 approved by the American Dental Association effective at the time the service was billed; and
(2) A claim form for all other health care providers shall consist of the HCFA - 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee effective at the time the service was billed.

Section 4. Retention of Records. A provider shall, upon request, provide a copy of the following to an insurer as support for a claim for reimbursement of a telehealth consultation:
(1) Written record which substantiates the request by the referring provider for the telehealth consultation by the primary care provider; and

(2) Written record of the telehealth consultation.

Section 5. Material Incorporated by Reference.

(1) The following material is incorporated by reference:
  (a) ADA Form - J588, "Dental Claim Form" (1999 version 2000); and
  (b) Form HCFA - 1500, "Health Insurance Claim Form" (12-90 Edition).

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Office of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (27 Ky.R. 2008; Am. 2540; 2781; eff. 4-9-2001; TAm **eff. 8-9-2007**.)

Department of Insurance - 806 KAR 17:500. Basic health benefit plan requirements.

www.lrc.ky.gov/kar/806/017/500.htm

RELATES TO: KRS 304.12-013, 304.14-020, 304.14-120, 304.14-140, 304.14-150, 304.14-180, 304.14-210, 304.14-360, 304.14-440, 304.14-450, 304.17-030, 304.17-042, 304.17-310, 304.17-313, 304.17-3165, 304.17-319, 304.17A-005, 304.17A-096-304.17A-132, 304.17A-135-304.17A-145, 304.17A-148-304.17A-149, 304.17A-155, 304.17A-171, 304.17A-250, 304.17A-258, 304.17A-520, 304.17A-647, 304.18-032, 304.18-0365-304.18-037, 304.18-0985, 304.32-153, 304.32-1585, 304.32-1595, 304.32-280, 304.38-1935-304.38-1937, 304.38-199, 304.38-210, 29 C.F.R. 2590.702(b), 2590.711, 2590.712, 29 U.S.C. 1185, 42 U.S.C. 300gg-4-300gg-6, 300gg-51, 300gg-52

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-096, 304.17A-097

NECESSITY, FUNCTION, AND CONFORMITY KRS 304.2-110(1) authorizes the executive director to promulgate administrative regulations necessary for or as an aid to the effectuation of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-096 authorizes an insurer that offers a health benefit plan to offer one (1) or more basic health benefit plans in Kentucky. EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as the head of the department. This administrative regulation establishes the requirements of a basic health benefit plan.

Section 1. Definitions.

(1) "Basic health benefit plan" is defined in KRS 304.17A-005(4).
(2) "Department" means Department of Insurance.
(3) "Health benefit plan" is defined in KRS 304.17A-005(22).
(4) "Insurer" is defined in KRS 304.17A-005(27).
(5) "Kentucky insurance code" means the statutes referenced in KRS 304.1-010 and the administrative regulations established in KAR Title 806.
(6) "State mandated health insurance benefit" means a requirement in the Kentucky insurance code that an insurer:
  (a) Provide a specified benefit;
  (b) Include a specified coverage; or
  (c) Pay, indemnify, or reimburse for a specified medical service.

Section 2. Disclosure Statement.
A disclosure statement as required under KRS 304.17A-097 shall:
(1) Accompany or be a part of the application for coverage under a basic health benefit plan;
(2) Be included in a basic health benefit plan policy and certificate of coverage;
(3) Meet the same requirements as the minimum standards for the readability and intelligibility of insurance contracts as established in 806 KAR 14:121; and
(4) List the state mandated health insurance benefit excluded in whole or in part from coverage under the basic health benefit plan.

Section 3. State Mandated Health Insurance Benefits.
A basic health benefit plan differs from a health benefit plan by the insurer electing to exclude one (1) or more of the following in whole or in part:
(1) Coverage of therapeutic foods, formulas, supplements, and low-protein modified food for the treatment of inborn errors of metabolism and genetic conditions as required under KRS 304.17A-258(2);
(2) Coverage of the treatment of temporomandibular joint disorders and craniomandibular jaw disorders as required under KRS 304.17-319, 304.18-0365, 304.32-1585, 304.38-1937, and 806 KAR 17:090;
(3) Coverage of the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation as required under KRS 304.17-3165, 304.17A-135, 304.18-0985, 304.32-1595, and 304.38-1936;
(4) Coverage of the treatment of human immunodeficiency virus infections as required under KRS 304.12-013(5);
(5) Coverage of cochlear implants as required under KRS 304.17A-131;
(6) Coverage of the treatment of autism in children as required under KRS 304.17A-143, and 806 KAR 17:460;
(7) Coverage of telehealth services as required under KRS 304.17A-138 and 806 KAR 17:270;
(8) Coverage of anesthesia and hospital or facility charges in connection with dental procedures as required under KRS 304.17A-149 and 806 KAR 17:095;
(9) Coverage of hearing aids and related services as required under KRS 304.17A-132;
(10) Coverage for dependents as required under KRS 304.17-310(1) and (2); or
(11) Coverage of a second opinion as required under KRS 304.17A-520(4).

Section 4. Basic Health Benefit Plan Requirements.
(1) Except for the exclusion of a state mandated health insurance benefit as established under KRS 304.17A-096, a basic health benefit plan shall comply with the applicable requirements of a health benefit plan as established under KRS Chapter 304, subtitles 12, 14, 17, 17A, 18, 32, and 38 and 806 KAR Chapters 12, 14, 17, 18, 32, and 38.
(2) A basic health benefit plan shall include a health insurance benefit as mandated under federal law pursuant to KRS 304.17A-096, including a benefit for the following:
   (a) Women's health and cancer as identified in 29 U.S.C. 1185b, 42 U.S.C. 300gg-6, or 42 U.S.C. 300gg-52;

(b) Parity in the application of limits to mental health benefits as identified in 42 U.S.C. 300gg-5 and 29 C.F.R. 2590.712 for a group basic health benefit plan;
(c) Newborns' and mothers' health as identified in 29 U.S.C. 1185, 42 U.S.C. 300gg-4, 42 U.S.C. 300gg-51, or 29 C.F.R. 2590.711;
(d) Treatment of an injury that results from an act of domestic violence or a medical condition as identified in 29 C.F.R. 2590.702(b)(2)(iii); and
(e) Nondiscrimination due to genetic information as identified in 29 C.F.R. 2590.702(b)(1) and 2590.702(b)(2)(i)(B).

(3) A basic health benefit plan shall be marketed, distributed, and issued by an insurer in the same manner as a health benefit plan.

Section 5. Annual Reporting Requirements.
An insurer offering a basic health benefit plan shall report to the department annually by April 1, on the form HIPMC-BHP-1, Basic Health Benefit Plan Annual Report, incorporated by reference in 806 KAR 17:005, the following information relating to a basic health benefit plan:
(1) Total premium by product type and market segment;
(2) Total enrollment by product type, market segment, and county; and
(3) Total number of individuals not covered under health insurance for a period of at least one (1) year prior to coverage under a basic health benefit plan. (32 Ky.R. 806; Am. 501; eff. 10-7-2005; 34 Ky.R. 1810; 2100; eff. 4-4-2008; 35 Ky.R. 634; **eff. 12-5-2008**.)

KENTUCKY BOARD OF MARRIAGE AND FAMILY THERAPISTS

KRS 335.380. Duty of treating marriage and family therapist utilizing telehealth to ensure patient's Informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31954

(1) A treating marriage and family therapist who provides or facilitates the use of telehealth shall ensure:
(a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
(b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
(a) Prevent abuse and fraud through the use of telehealth services;
(b) Prevent fee-splitting through the use of telehealth services; and
(c) Utilize telehealth in the provision of marriage and family therapy services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000

History: Created 2000 Ky. Acts ch. 376, sec. 21, effective July 14, 2000.

DEPARTMENT FOR MEDICAID SERVICES

KRS 205.510. Definitions for medical assistance law.
www.lrc.ky.gov/Statutes/statute.aspx?id=7695

As used in this chapter as it pertains to medical assistance unless the context clearly requires a different meaning:

(1) "Chiropractor" means a person authorized to practice chiropractic under KRS Chapter 312;
(2) "Council" means the Advisory Council for Medical Assistance;
(3) "Dentist" means a person authorized to practice dentistry under laws of the Commonwealth;
(4) "Health professional" means a physician, physician assistant, nurse, doctor of chiropractic, mental health professional, optometrist, dentist, or allied health professional who is licensed in Kentucky;
(5) "Medical care" as used in this chapter means essential medical, surgical, chiropractic, dental, optometric, podiatric, telehealth, and nursing services, in the home, office, clinic, or other suitable places, which are provided or prescribed by physicians, optometrists, podiatrists, or dentists licensed to render such services, including drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic services, nursing-home and convalescent care, hospital care as defined in KRS 205.560(1)(a), and such other essential medical services and supplies as may be prescribed by such persons; but not including abortions, or induced miscarriages or premature births, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment or except in induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. However, this section does not authorize optometrists to perform any services other than those authorized by KRS Chapter 320;
(6) "Nurse" means a person authorized to practice professional nursing under the laws of the Commonwealth;
(7) "Nursing home" means a facility which provides routine medical care in which physicians regularly visit patients, which provide nursing services and procedures employed in caring for the sick which require training, judgment, technical knowledge, and skills beyond that which the untrained person possesses, and which maintains complete records on patient care, and which is licensed pursuant to the provisions of KRS 216B.015;
(8) "Optometrist" means a person authorized to practice optometry under the laws of the Commonwealth;
(9) "Other persons eligible for medical assistance" may include the categorically needy excluded from money payment status by state requirements and classifications of medically needy individuals

as permitted by federal laws and regulations and as prescribed by administrative regulation of the secretary for health and family services or his designee;

(10) "Pharmacist" means a person authorized to practice pharmacy under the laws of the Commonwealth;

(11) "Physician" means a person authorized to practice medicine or osteopathy under the laws of the Commonwealth;

(12) "Podiatrist" means a person authorized to practice podiatry under the laws of the Commonwealth;

(13) "Primary-care center" means a facility which provides comprehensive medical care with emphasis on the prevention of disease and the maintenance of the patients' health as opposed to the treatment of disease;

(14) "Public assistance recipient" means a person who has been certified by the Department for Community Based Services of the Cabinet for Health and Family Services as being eligible for, and a recipient of, public assistance under the provisions of this chapter;

(15) "Telehealth consultation" means a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to:

(a) Compressed digital interactive video, audio, or data transmission;

(b) Clinical data transmission via computer imaging for teleradiology or telepathology; and

(c) Other technology that facilitates access to health care services or medical specialty expertise;

(16) "Third party" means an individual, institution, corporation, company, insurance company, personal representative, administrator, executor, trustee, or public or private agency, including, but not limited to, a reparation obligor and the assigned claims bureau under the Motor Vehicle Reparations Act, Subtitle 39 of KRS Chapter 304, who is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient of medical assistance provided under Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 et seq.; and

(17) "Vendor payment" means a payment for medical care which is paid by the Cabinet for Health and Family Services directly to the authorized person or institution which rendered medical care to an eligible recipient.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 227, effective June 20, 2005. – Amended 2000 Ky. Acts ch. 14, sec. 32, effective July 14, 2000; and ch. 376, sec. 3, effective July 15, 2001. -- Amended 1998 Ky. Acts ch. 426, sec. 194, effective July 15, 1998. - - Amended 1980 Ky. Acts ch. 135, sec. 28, effective July 15, 1980; and ch. 252, sec. 1, effective July 15, 1980. -- Amended 1978 Ky. Acts ch. 140, sec. 2, effective June 17, 1978. -- Amended 1976 Ky. Acts ch. 119, sec. 1. -- Amended 1974 Ky. Acts ch. 74, Art. VI, sec. 107(1), (15), (16) and (19); ch. 225, sec. 1; and ch. 308, sec. 38. -- Amended 1972 Ky. Acts ch. 256, sec. 15. -- Amended 1970 Ky. Acts ch. 78, sec. 1. -- Amended 1963 (2d Extra. Sess.) Ky. Acts ch. 2, sec. 1. -- Amended 1960 (1st Extra. Sess.) Ky. Acts ch. 2, sec. 1. -- Created 1960 Ky. Acts ch. 68, Art. VII, sec. 3.

Legislative Research Commission Note (7/15/2001). Under 2000 Ky. Acts ch. 376, sec. 24(1), this version of the statute takes effect "on July 15, 2001, or upon approval of any federal waivers, whichever first occurs." Because federal waivers were not approved, the effective date is July 15, 2001.

Department for Medicaid Services - KRS 205.520. Title and purpose of KRS 205.510 to 205.630 -- Recovery from third parties for services rendered.
www.lrc.ky.gov/Statutes/statute.aspx?id=7700

(1) KRS 205.510 to 205.630 shall be known as the "Medical Assistance Act."
(2) The General Assembly of the Commonwealth of Kentucky recognizes and declares that it is an essential function, duty, and responsibility of the state government to provide medical care to its indigent citizenry; and it is the purpose of KRS 205.510 to 205.630 to provide such care.
(3) Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.
(4) It is the intention of the General Assembly to comply with the provisions of Title XIX of the Social Security Act which require that the Kentucky Medical Assistance Program recover from third parties which have a legal liability to pay for care and services paid by the Kentucky Medical Assistance Program.
(5) The Kentucky Medical Assistance Program shall be the payor of last resort and its right to recover under KRS 205.622 to 205.630 shall be superior to any right of reimbursement, subrogation, or indemnity of any liable third party.

Effective: June 20, 2005
History: Amended 2005 Ky. Acts ch. 99, sec. 228, effective June 20, 2005. – Amended 1998 Ky. Acts ch. 426, sec. 195, effective July 15, 1998. -- Amended 1982 Ky. Acts ch. 248, sec. 1, effective July 15, 1982. -- Amended 1980 Ky. Acts ch. 188, sec. 124, effective July 15, 1980; and ch. 252, sec. 2, effective July 15, 1980. – Amended 1979 (1st Extra. Sess.) Ky. Acts ch. 2, sec. 8, effective February 10, 1979. -- Amended 1974 Ky. Acts ch. 74, Art. VI, sec. 107(1), (15), (16) and (19). – Amended 1966 Ky. Acts ch. 134, sec. 6. -- Created 1960 Ky. Acts ch. 68, Art. VII, secs. 1 and 2.

Department for Medical Services - 907 KAR 1:055. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services. www.lrc.ky.gov/kar/907/001/055.htm

RELATES TO: KRS 205.560, 216B.010, 216B.105, 216B.130, 216B.990, 42 C.F.R. 413, 438.60, 491, Subpart A, 440.130, 440.230, 447.3251, 45 C.F.R. 74.27, 48 C.F.R. Part 31, 42 U.S.C. 1396a, b, d
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 216B.042, 42 U.S.C. 1396a
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Department for Medicaid Services' reimbursement policies for primary care

center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

Section 1. Definitions.

(1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Alternative payment methodology" or "APM" means a reimbursement that is an alternative to the standard reimbursement established in Section 3 of this administrative regulation in accordance with 42 U.S.C. 1396a(bb)(6).

(3) "Audit" means an examination that may be full or limited in scope of a federally-qualified health center's, federally-qualified health center look-alike's, rural health clinic's, or primary care center's:
   (a) Financial transactions, accounts, and reports; and
   (b) Compliance with applicable Medicare and Medicaid regulations, manual instructions, and directives.

(4) "Base year" means the first full fiscal year following the effective date of an FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid program:
   (a) In which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation as designated by the FQHC, FQHC look-alike, or RHC; and
   (b) Not to exceed twenty-four (24) months past the effective date that the FQHC, FQHC look-alike, or RHC was enrolled with the department.

(5) "Certified psychologist with autonomous functioning" means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.

(6) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(7) "Change in scope of service" means a change in the type, intensity, duration, or amount of service.

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

(9) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(11) "Federally-qualified health center" or "FQHC" is defined in 42 C.F.R. 405.2401.

(12) "Federally-qualified health center look-alike" or "FQHC look-alike" means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally-qualified health center look-alike.

(13) "Final PPS rate" means an all-inclusive reimbursement amount per visit for an FQHC, FQHC look-alike, or RHC that:
   (a) Is unique to the FQHC, FQHC look-alike, or RHC;
   (b) Encompasses reimbursement for all services rendered during the visit;
   (c) Is based on:
      1. Twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation:

a. Submitted to the department by the FQHC, FQHC look-alike, or RHC; and
b. That has been reviewed and approved by the department; and

2. A paid claims listing corresponding to the twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation; and

(d) Is established by the department.

(14) "Health care provider" means, for:

(a) A primary care center, an FQHC, an FQHC look-alike, or an RHC:

1. A licensed physician;
2. A licensed osteopathic physician;
3. A licensed podiatrist;
4. A licensed optometrist;
5. An advanced practice registered nurse;
6. A licensed dentist or oral surgeon;
7. A physician assistant;
8. A licensed clinical social worker;
9. A licensed psychologist;
10. A licensed marriage and family therapist;
11. A licensed professional clinical counselor;
12. A licensed psychological practitioner;
13. A certified psychologist with autonomous functioning; or
14. A practitioner who is:
    a. Authorized pursuant to 907 KAR 1:054 to provide services in a PCC, an FQHC, an FQHC look-alike, or an RHC; and
    b. Not listed in subparagraphs 1 through 13 of this paragraph; or

(b) An FQHC or FQHC look-alike, in addition to the professionals established in paragraph (a) of this subsection:

1. A resident in the presence of a teaching physician; or
2. A resident without the presence of a teaching physician if:
    a. The services are furnished in an FQHC or FQHC look-alike in which the time spent by the resident in performing patient care is included in determining any intermediary payment to a hospital in accordance with 42 C.F.R. 413.75 through 413.83;
    b. The resident furnishing the service without the presence of a teaching physician has completed more than six (6) months of an approved residency program;
    c. The teaching physician:
        (i) Does not direct the care of more than four (4) residents at any given time; and
        (ii) Directs care from a proximity that constitutes immediate availability; and
    d. The teaching physician:
        (i) Has no other responsibilities at the time;
        (ii) Has management responsibility for any recipient seen by the resident;
        (iii) Ensures that the services furnished are appropriate;

(iv) Reviews with the resident, during or immediately after each visit by a recipient, the recipient's medical history, physical examination, diagnosis, and record of tests or therapies; and

(v) Documents the extent of the teaching physician's participation in the review and direction of the services furnished to each recipient.

(15) "Interim PPS rate" means an all-inclusive per visit reimbursement amount established by the department to pay an FQHC, FQHC look-alike, or an RHC for covered services prior to the establishment of a final PPS rate.

(16) "Licensed clinical social worker" means an individual who is currently licensed in accordance with KRS 335.100.

(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(19) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(20) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(21) "Medical Group Management Association Medical Directorship and On-Call Compensation Survey" means a report developed and owned by the Medical Group Management Association that:

(a) Highlights the critical relationship between medical director compensation and time spent in the medical director function;

(b) Aligns medical director compensation with time spent as medical director; and

(c) Contains tables illustrating the relationship of medical director salary to time spent in the medical director function.

(22) "Medical Group Management Association Physician Compensation and Production Survey Report" means a report developed and owned by the Medical Group Management Association that:

(a) Highlights the critical relationship between physician salaries and productivity;

(b) Is used to align physician salaries and benefits with provider production; and

(c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and
2. Comprehensive and summary data tables that cover many specialties.

(23) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(24) "Medicare Economic Index" or "MEI" means the economic index referred to in 42 U.S.C. 1395u(b)(3)(L).

(25) "Paid claims listing" means a report of claims paid by the department for a given FQHC, FQHC look-alike, or RHC.

(26) "Parent facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that is:

(a) Licensed and operating with a unique Kentucky Medicaid program provider number;

(b) Operating under the same management as a satellite facility; and

(c) The original facility that existed prior to the existence of a satellite facility.

(27) "PCC" or "primary care center" means an entity that is currently licensed as a PCC in accordance with 902 KAR 20:058.

(28) "Percentage increase in the MEI" is defined in 42 U.S.C. 1395u(i)(3).

(29) "Physician assistant" is defined by KRS 311.840(3).

(30) "PPS" means prospective payment system.

(31) "Rate year" means, for the purposes of the MEI, the twelve (12) month period beginning July 1 of each year for which a rate is established for an FQHC, FQHC look-alike, or RHC under the prospective payment system.

(32) "Reasonable cost" means:

(a) A cost as determined by the:

1. Applicable Medicare cost reimbursement principles established in 42 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and
2. Medical Group Management Association Physician Compensation and Production Survey Report for the applicable year and region; and

(b) Costs determined to be reasonable in accordance with a comprehensive desk review or audit.

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

(34) "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).

(35) "Satellite facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that:

(a) Is at a different location than the parent facility; and

(b) Operates under the same management as the parent facility.

(36) "Telehealth" means two (2)-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment.

(37) "Visit" means an encounter:

(a) Between a recipient or enrollee and a health care provider during which an FQHC, FQHC look-alike, or RHC service is delivered; and

(b) That occurs:

1. In person; or
2. Via telehealth if authorized by 907 KAR 3:170.

Section 2. Provider Participation Requirements.

(1) (a) A participating FQHC, FQHC look-alike, RHC, or PCC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
2. Except as established in paragraph (c) of this subsection, participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:

1. Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;
2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and
3. Comply with 907 KAR 1:671.

(c) In accordance with 907 KAR 17:015, Section 3(3), an FQHC, FQHC look-alike, RHC, or PCC that provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2) (a) To be initially enrolled with the department, an:
1. FQHC or FQHC look-alike shall:
a. Enroll in accordance with 907 KAR 1:672; and
b. Submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or
2. RHC shall:
a. Enroll in accordance with 907 KAR 1:672; and
b. Submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General.

(b) To remain enrolled and participating in the Kentucky Medicaid program, an:
1. FQHC or FQHC look-alike shall:
a. Comply with the enrollment requirements established in 907 KAR 1:672;
b. Comply with the participation requirements established in 907 KAR 1:671; and
c. Annually submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or
2. RHC shall:
a. Comply with the enrollment requirements established in 907 KAR 1:672;
b. Comply with the participation requirements established in 907 KAR 1:671; and
c. Annually submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General.

(c) The requirements established in paragraphs (a) and (b) of this subsection shall apply to a satellite facility of an FQHC or FQHC look-alike.

(3) (a) An FQHC or FQHC look-alike that operates multiple satellite facilities shall:
1. List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and
2. Consolidate claims and cost report data of its satellite facilities with the parent facility.

(b) A PCC that operates multiple satellite facilities shall list each satellite facility on the parent facility's license in accordance with 902 KAR 20:058.

(4) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal participation shall be terminated from Kentucky Medicaid program participation.

(5) A participating:
(a) FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC;
(b) FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike;
(c) RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an RHC; or

(d) PCC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of a PCC.

(6) An FQHC, FQHC look-alike, RHC, or PCC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a Visit by a Recipient Who is not an Enrollee and that is Covered by the Department.

(1) Except as established in Section 5 or Section 9 of this administrative regulation, for a visit by a recipient who is not an enrollee and that is covered by the department, the department shall reimburse:
   (a) An FQHC, FQHC look-alike, or RHC a final PPS rate as required by 42 U.S.C. 1396a(bb); or
   (b) A satellite facility of an FQHC or FQHC look-alike a final PPS rate as required by 42 U.S.C. 1396a(bb).

(2) Costs related to outpatient drugs or pharmacy services shall be excluded from the PPS rate referenced in subsection (1) of this section.

(3) The department shall calculate a final PPS rate for a new FQHC, FQHC look-alike, or RHC in accordance with Section 4 of this administrative regulation.

(4) The department shall adjust a final PPS rate:
   (a) By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year;
   (b) In accordance with Section 10 of this administrative regulation:
      1. Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
      2. Upon review and determination by the department that there has been a change in scope of services; and
   (c) If necessary as a result of a desk review or audit.

(5) A final PPS rate established in accordance with this administrative regulation shall not be subject to an end of the year cost settlement.

Section 4. Establishment of a Final PPS Rate for a New FQHC, FQHC look-alike, or RHC.

(1) (a) The department shall establish a final PPS rate to reimburse a new FQHC, FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid covered services utilizing information from the FQHC's, FQHC look-alike's, or RHC's base year upon completion of a comprehensive desk review or audit of an FQHC's, FQHC look-alike's, or RHC's Universal Cost Report.
   (b) Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, or RHC an interim PPS rate, the final PPS rate established for an FQHC, FQHC look-alike, or RHC shall:
      1. Be prospective; and
      2. Not settled to cost.

(2) The department shall determine the reasonable costs of an FQHC, FQHC look-alike, or RHC based on the:

(a) Universal Cost Report:
1. Submitted by the FQHC, FQHC look-alike, or RHC to the department and prepared by the FQHC, FQHC look-alike, or RHC in accordance with the Universal Cost Report Instructions; and
2. That contains twelve (12) full months of operating data for the designated base year;

(b) Department's review of the Universal Cost Report referenced in paragraph (a) of this subsection; and

(c) Costs and visits as adjusted by the department for full-time operation for a facility that is not in operation at least forty (40) hours per week.

(3) (a) An FQHC, FQHC look-alike, or RHC shall submit a Universal Cost Report to the department by the end of the fifth month following the end of the FQHC's, FQHC look-alike's, or RHC's designated base year.

(b) The department shall:
1. Review the Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the Universal Cost Report; and
2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary.

(c) 1. If additional documentation is necessary to establish a final PPS rate, the FQHC, FQHC look-alike, or RHC shall:
a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
b. Request an extension beyond thirty (30) days to provide the additional documentation.
2. The department shall grant no more than one (1) extension.
3. An extension shall not exceed thirty (30) days.

(d) 1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation until:
a. The additional documentation has been received by the department; and
b. The department has established a final PPS rate.
2. If an FQHC, FQHC look-alike, or RHC does not submit a Universal Cost Report to the department, the department shall reimburse the FQHC, FQHC look-alike, or RHC as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation until the FQHC, FQHC look-alike, or RHC submits a Universal Cost Report to the department.

(e) The department shall review an FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraph (a) of this subsection.

(f) 1. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's, or RHC's paid claims listing, the department shall:
   a. Establish a final PPS rate for the FQHC, FQHC look-alike, or RHC; and
   b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:
      (i) Final PPS rate; and
      (ii) Appeal rights regarding the PPS final rate.
2. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after an FQHC's, FQHC look-alike's, or RHC's fiscal year end.
3. If an FQHC, FQHC look-alike, or RHC has not submitted all necessary information to the department to establish a final PPS rate, the department shall continue to pay the FQHC, FQHC look-alike, or RHC as it pays primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation.

(4) Along with a Universal Cost Report, an FQHC, FQHC look-alike, or RHC shall submit to the department a written statement of the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 5. Interim Reimbursement for a New FQHC, FQHC Look-alike, or RHC.

(1) (a) Until a final PPS rate is established for an FQHC, FQHC look-alike, or RHC, the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim PPS rate based on the average final PPS rates of entities with similar caseloads.

(b) To identify an entity with a similar caseload, the department shall consider:
1. Entity type (FQHC, FQHC look-alike, or RHC);
2. Managed care organization region;
3. Operating hours per day, days per week, and weeks per year; and
4. Specialty services, obstetrical services, or hospital-based entities, if applicable.

(2) If no entity with a similar caseload exists, the department shall establish an interim PPS rate using cost reporting methods.

(3) After the department establishes a final PPS rate for an FQHC, FQHC look-alike, or RHC, the department shall retroactively adjust reimbursement to the FQHC, FQHC look-alike, or RHC that was made on an interim basis to comport with the final PPS rate.

(4) An FQHC, FQHC look-alike, or RHC, upon enrolling with the Medicaid Program, shall submit in writing to the department a statement stating the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 6. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by an MCO.

(1) For a service or drug provided to an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC and that is covered by an MCO, the PCC's reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the managed care organization with whom the enrollee is enrolled.

(2) The department shall not supplement the reimbursement referenced in subsection (1) of this section.

Section 7. Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by the Department.

(1) (a) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse the rate or reimbursement established for the service or drug on the current Kentucky-specific Medicare Physician Fee Schedule.

(b) 1. Except as provided in subparagraph 3. of this paragraph, if no rate or reimbursement exists on the Kentucky-specific Medicare Physician's Fee schedule for a service or drug referenced in paragraph (a) of this subsection, the department shall reimburse for the service or drug the same amount that the department reimburses for the service or drug pursuant to the applicable administrative regulation established in Title 907 KAR.

2. For example, if no reimbursement exists on the current Kentucky-specific Medicare Physician Fee Schedule for a:

a. Dental service, the department shall reimburse for the dental service pursuant to 907 KAR 1:626; or

b. Given physician's service, the department shall reimburse for the service pursuant to 907 KAR 3:010.

3. The department shall reimburse a rate equal to seventy-five (75) percent of the rate it pays a physician pursuant to 907 KAR 3:010 for a physician's service that:

a. Does not exist on the current Kentucky-specific Medicare Physician Fee Schedule; and

b. Is provided by an APRN or physician assistant.

(2) The reimbursement referenced in subsection (1) of this section shall not exceed the federal upper payment limit determined in accordance with 42 C.F.R. 447.321.

(3) (a) The coverage provisions and requirements established in 907 KAR 3:005 shall apply to a service or drug provided by a PCC.

(b) If a Medicare coverage provision or requirement exists regarding a given service or drug that contradicts a provision or requirement established in 907 KAR 3:005, the provision or requirement established in 907 KAR 3:005 shall supersede the Medicare provision or requirement.

Section 8. Supplemental Reimbursement for FQHC Visits, FQHC Look-Alike Visits, and RHC Visits. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to Sections 3, 4, 5, or 9 of this administrative regulation, the department shall supplement the reimbursement made by the managed care organization in a manner that:

(1) Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it had been made in accordance with Sections 3, 4, 5, or 9 of this administrative regulation;

(2) Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and

(3) Ensures that total reimbursement does not exceed the federal upper payment limit in accordance with 42 C.F.R. 447.304.

Section 9. Alternative Payment Methodology for an FQHC, FQHC Look-alike, or RHC.

(1) (a) The department shall pay to an FQHC, FQHC look-alike, or RHC, for which a final PPS rate exists, an alternative payment methodology if the FQHC, FQHC look-alike, or RHC notifies the department in writing that it requests to receive the alternate reimbursement.

(b) 1. The APM shall equal 125 percent of the Medicare upper payment limit for rural health clinics in effect on September 30, 2014.

2. The APM referenced in subparagraph 1 of this paragraph shall not be adjusted for inflation.

(c) An FQHC, FQHC look-alike, or RHC that had an interim PPS rate prior to November 1, 2015 may request the APM as an interim PPS rate until the FQHC's, FQHC look-alike's, or RHC's final PPS rate is established.

(2) (a) An APM established in this section shall be effective for dates of service beginning with the date requested in writing by an FQHC, FQHC look-alike, or RHC except as established in paragraph (b) of this subsection.

(b) An APM effective date shall not precede the date in which the department received the written request for the APM.

Section 10. Change in Scope and Final PPS Rate Adjustment.

(1) (a) If an FQHC, FQHC look-alike, or RHC changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's final PPS rate if the change in scope qualifies for an adjustment in accordance with this section upon departmental review and approval of the change in scope.

(b) An adjustment to a final PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be effective to the date that the change in scope occurred.

(c) 1. A revised PPS rate shall be calculated in accordance with the MAP 100501.

2. A revised PPS rate shall not be rebased.

(2) A change in scope of service shall be restricted to:

(a) Adding or deleting a covered service;

(b) Increasing or decreasing the intensity of a covered service pursuant to subsection (5) of this section; or

(c) A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC.

(3) The following items individually shall not constitute a change in scope:

(a) A general increase or decrease in the costs of existing services;

(b) A reduction or an expansion of hours per day, days per week, or weeks per year;

(c) An addition of a new site that provides the same Medicaid covered services;

(d) A wage increase;

(e) A renovation or other capital expenditure;

(f) A change in ownership; or

(g) An addition or deletion of a service provided by a non-licensed professional or specialist.

(4) (a) An addition of a covered service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.

(b) The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the FQHC, FQHC look-alike, or RHC by the licensed professional staff member.

(5) A change in intensity shall:

(a) Include a material change;

(b) Increase or decrease the existing final PPS rate by at least five (5) percent; and

(c) Last at least twelve (12) months.

(6) The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:

(a) A government entity imposes a mandatory minimum wage increase and the increase was:

1. Not included in the calculation of the final PPS rate; or
2. Subsequently included in the MEI applied yearly; or

(b) 1. A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class.

2. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

(7) A requested change in scope shall:

(a) Increase or decrease the existing final PPS rate by at least five (5) percent;

(b) Last at least twelve (12) months; and

(c) Be submitted to the department in writing.

(8) (a) An FQHC, FQHC look-alike, or RHC that requests a change in scope shall submit the following documents to the department within six (6) months of the requested effective date of a change in scope:

1. A narrative describing the change in scope;
2. A completed MAP 100501, Prospective Payment System Rate Adjustment, completed according to the Instructions for Completing the MAP 100501 Form; and
3. A signed letter requesting the change in scope.

(b) If the department does not receive the documentation required regarding a change in scope within six (6) months after the requested effective date of a change in scope, the change in scope shall be denied.

(c) 1. The department shall:

a. Review the documentation listed in this subsection; and

b. Notify the FQHC, FQHC look-alike, or RHC in writing of the:

(i) Approval or denial of the request for change in scope within ninety (90) business days from the date the department received the request; or

(ii) Need for additional documentation from the FQHC, FQHC look-alike, or RHC to establish an interim PPS rate associated with the change in scope.

2. If the department requests additional documentation to calculate the interim PPS rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:
   a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
   b. Request an extension beyond thirty (30) days to provide the additional documentation.
3. a. The department shall grant no more than one (1) extension.
   b. An extension shall not exceed thirty (30) days.
4. If the department approves the request for a change in scope and receives all of the necessary documentation from an FQHC, FQHC look-alike, or RHC within the timelines established in this section, the department shall establish an interim PPS rate for the FQHC, FQHC look-alike, or RHC based on the projected costs contained in the completed MAP 100501, Prospective Payment System Rate Adjustment referenced in paragraph (a)2 of this subsection.

(9) (a) To establish a PPS final rate resulting from a change in scope, the department shall use a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report submitted by the FQHC, FQHC look-alike, or RHC to the department that contains twelve (12) months of cost data for the first full fiscal year end after the effective date of the change in scope.

(b) Within six (6) months of the end of the twelve (12) month cost data period referenced in paragraph (a) of this subsection, the FQHC, FQHC look-alike, or RHC shall submit to the department the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report containing cost data corresponding to the twelve (12) month cost data for the first full fiscal year end after the effective date of the change in scope.

(c) The department shall:
1. Review the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report; and
2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary.

(d) 1. If additional documentation is necessary to establish a PPS final rate, the FQHC, FQHC look-alike, or RHC shall:
   a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
   b. Request an extension beyond thirty (30) days to provide the additional documentation.
2. The department shall grant no more than one (1) extension.
3. An extension shall not exceed thirty (30) days.

(e) 1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC the FQHC's,

FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC's, FQHC look-alike's, or RHC's request for a change in scope until:

a. The additional documentation has been received by the department; and
b. The department establishes a new final PPS rate associated with the change in scope.

2. If an FQHC, FQHC look-alike, or RHC does not submit a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report to the department in accordance with paragraph (b) of this subsection, the department shall:
   a. Not issue a new PPS final rate associated with the change in scope; and
   b. Revert to paying the FQHC, FQHC look-alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC, FQHC look-alike, or RHC requesting a change in scope.

(f) 1. If any service included in a change in scope is a service that can be identified on a paid claims listing, the department shall review the FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraphs (a) and (b) of this subsection.

2. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's, or RHC's paid claims listing, the department shall:
   a. Establish a final PPS rate, resulting from the change in scope, for the FQHC, FQHC look-alike, or RHC; and
   b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:
      (i) Final PPS rate; and
      (ii) Appeal rights regarding the PPS final rate.

3. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after the end of the FQHC's, FQHC look-alike's, or RHC's cost report period associated with the change in scope.

(g) 1. If no service included in a change in scope can be identified on a paid claims listing, and the department has received a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report referenced in paragraphs (a) and (b) of this subsection, and no additional documentation is needed from the FQHC, FQHC look-alike, or RHC, the department shall:
   a. Not review a paid claims listing in establishing a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope; and
   b. Establish a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope within ninety (90) days of receiving the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report.

Section 11. Limitations and Exclusions.

(1) (a) Except for a case in which a recipient or enrollee, subsequent to the first encounter at an FQHC, FQHC look-alike, or RHC, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider or multiple encounters

with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

(b) The limit established in paragraph (a) of this subsection shall:

1. Apply to an FQHC, FQHC look-alike, or RHC; and
2. Not apply to a PCC that is not an FQHC, FQHC look-alike, or RHC.

(2) (a) Except as established in paragraph (b) of this subsection, a vaccine available without charge to an FQHC, FQHC look-alike, RHC, or PCC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

(b) Adult flu vaccine costs shall be allowed as Medicaid costs reported on a Universal Cost Report.

(3) The department shall not reimburse for services provided by an FQHC, FQHC look-alike, PCC, or RHC to a recipient in a hospital unless the FQHC, FQHC look-alike, PCC, or RHC has previously, any time prior to the hospital admission, provided a service to the recipient at the FQHC's, FQHC look-alike's, PCC's, or RHC's location.

Section 12. Out-of-State Providers.

(1) Except as established in subsection (2) of this section, reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be based on the rate on file with the FQHC's, FQHC look-alike's, or RHC's state Medicaid agency.

(2) If an out-of-state FQHC's, FQHC look-alike's, or RHC's reimbursement is an APM, the department's reimbursement to the out-of-state FQHC, FQHC look-alike, or RHC shall:

(a) Not be the APM the FQHC, FQHC look-alike, or RHC receives in its state; and

(b) Be the final PPS rate that the FQHC, FQHC look-alike, or RHC would receive in its state if it were not receiving an APM.

Section 13. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

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

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

Section 14. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) (a) 907 KAR 1:054; or

(b) 907 KAR 1:082; and

(2) This administrative regulation.

Section 15. Appeal Rights. An FQHC, FQHC look-alike, PCC, or RHC may appeal a department decision as to the application of this administrative regulation as it impacts the facility's reimbursement rate in accordance with 907 KAR 1:671.

Section 16. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "MAP 100501, Prospective Payment System Rate Adjustment", February 2013 edition;
(b) "Instructions for Completing the MAP 100501 Form", February 2013 edition;
(c) "Universal Cost Report", May 2015; and
(d) "Universal Cost Report Instructions", May 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:055, 5-2-1986; Am. 13 Ky.R. 389; eff. 9-4-1986; 15 Ky.R. 1326; eff. 12-13-1988; 1981; eff. 3-15-1989; 16 Ky.R. 281; eff. 9-20-1989; 2601; eff. 6-27-1990; 18 Ky.R. 543; eff. 10-6-1991; 29 Ky.R. 824; 1279; eff. 10-16-2002; 40 Ky.R. 49; 299; eff. 9-6-2013; 41 Ky.R. 2674; 42 Ky.R. 782; 1208; **eff. 11-6-2015**.)

Department for Medicaid Services - 907 KAR 3:005. Coverage of physicians' services.

www.lrc.ky.gov/kar/907/003/005.htm

RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184, 440.50, 447.26, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d-8, 1396a(a)(19), (30)

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

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to physicians' services.

Section 1. Definitions.

(1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Behavioral health practitioner under supervision" means an individual who is:
(a) A licensed psychological associate;
(b) A licensed professional counselor associate;
(c) A certified social worker;
(d) A marriage and family therapy associate;
(e) A licensed professional art therapist associate;
(f) A licensed assistant behavior analyst;
(g) A physician assistant working under the supervision of a physician; or
(h) A certified alcohol and drug counselor.

(3) "Common practice" means an arrangement through which a physician assistant administers health care services under the supervision of a physician via a supervisory relationship that has been approved by the Kentucky Board of Medical Licensure.

(4) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Designated controlled substance provider" means the provider designated as a lock-in recipient's controlled substance prescriber:
  (a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or
  (b) As established by the managed care organization in which the lock-in recipient is enrolled, if the lock-in recipient is an enrollee.

(7) "Designated primary care provider" means the provider designated as a lock-in recipient's primary care provider:
  (a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or
  (b) As established by the managed care organization in which the lock-in recipient is enrolled, if the lock-in recipient is an enrollee.

(8) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(9) "Early and periodic screening and diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).

(10) "Emergency care" means:
  (a) Covered inpatient or outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or
  (b) Emergency ambulance transport.

(11) "Enrollee" means a recipient who is enrolled with a managed care organization.

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

(13) "Global period" means the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(14) "Graduate medical education program" or "GME Program" means:
  (a) A residency program approved by:
    1. The Accreditation Council for Graduate Medical Education of the American Medical Association;
    2. The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;
    3. The Commission on Dental Accreditation of the American Dental Association; or
    4. The Council on Podiatric Medicine Education of the American Podiatric Medical Association; or
  (b) An approved medical residency program as defined in 42 C.F.R. 413.75(b).

(15) "Incidental" means that a medical procedure:
  (a) Is performed at the same time as a primary procedure; and
  (b) 1. Requires little additional resources; or
    2. Is clinically integral to the performance of the primary procedure.

(16) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(17) "Lock-in recipient" means:
  (a) A recipient enrolled in the lock-in program in accordance with 907 KAR 1:677; or
  (b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 8.

(18) "Locum tenens APRN" means an APRN:
(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and
(b) Whose services are billed under the APRN's provider number.
(19) "Locum tenens physician" means a substitute physician:
(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and
(b) Whose services are paid under the participating physician's provider number.
(20) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.
(21) "Medicaid basis" means a scenario in which:
(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:
1. 907 KAR 1:671; and
2. 907 KAR 1:672;
(b) The Medicaid Program is the payer for the service; and
(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.
(22) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(23) "Medical resident" means:
(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or
(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:
1. An individual with a:
a. Temporary license;
b. Resident training license; or
c. Restricted license; or
2. An unlicensed graduate of a foreign medical school.
(24) "Mutually exclusive" means that two (2) procedures:
(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;
(b) Represent two (2) methods of performing the same procedure;
(c) Represent medically impossible or improbable use of CPT codes; or
(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.
(25) "Non-Medicaid basis" means a scenario in which:
(a) A provider provides a service to a recipient;
(b) The Medicaid Program is not the payer for the service; and
(c) The recipient is liable for payment to the provider for the service.
(26) "Other licensed medical professional" means a health care provider:

(a) Other than a physician, physician assistant, advanced practice registered nurse, certified registered nurse anesthetist, nurse midwife, or registered nurse; and
(b) Who has been approved to practice a medical specialty by the appropriate licensure board.

(27) "Other provider preventable condition" is defined in 42 C.F.R. 447.26(b).
(28) "Physician assistant" is defined in KRS 311.840(3).
(29) "Physician injectable drug" means an injectable, infused, or inhaled drug or biological that:
(a) Is not typically self-administered;
(b) Is not excluded as a noncovered immunization or vaccine;
(c) Requires special handling, storage, shipping, dosing, or administration; and
(d) Is a rebatable drug.
(30) "Podiatrist" is defined by KRS 205.510(12).
(31) "Provider group" means a group of at least:
(a) Two (2) individually licensed physicians who:
1. Are enrolled with the Medicaid Program individually and as a group; and
2. Share the same Medicaid group provider number; or
(b) One (1) APRN and at least one (1) physician who:
1. Are enrolled with the Medicaid Program individually and as a group; and
2. Share the same Medicaid group provider number.
(32) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).
(33) "Recipient" is defined by KRS 205.8451(9).
(34) "Screening" means the evaluation of a recipient by a physician to determine:
(a) If a disease or medical condition is present; and
(b) If further evaluation, diagnostic testing, or treatment is needed.
(35) "Supervising physician" is defined in KRS 311.840(4).
(36) "Supervision" is defined in KRS 311.840(6).
(37) "Timely filing" means receipt of a Medicaid claim by the department:
(a) Within twelve (12) months of the date the service was provided;
(b) Within twelve (12) months of the date retroactive eligibility was established; or
(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.
(38) "Unlisted procedure or service" means a procedure or service:
(a) For which there is not a specific CPT code; and
(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation.

(1) (a) A participating physician shall:
1. Be licensed as a physician in the state in which the medical practice is located;
2. Comply with the:
a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672; and
b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164;
3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:
1. If the recipient agrees to receive the service on a non-Medicaid basis before the service begins; and
2. The service is not a Medicaid-covered service.

(c) 1. If a provider renders a Medicaid-covered service to a recipient, regardless of if the service is billed through the provider's Medicaid provider number or any other entity including a non-Medicaid provider, the recipient shall not be billed for the service.
2. The department shall terminate from Medicaid Program participation a provider who participates in an arrangement in which an entity bills a recipient for a Medicaid-covered service rendered by the provider.

(2) If a provider agrees to provide services to a recipient, the provider:
(a) Shall bill the department rather than the recipient for a covered service;
(b) May bill the recipient for a service not covered by Medicaid if the physician informed the recipient of noncoverage prior to providing the service; and
(c) Shall not bill the recipient for a service that is denied by the department on the basis of:
1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;
2. Incorrect billing procedures, including incorrect bundling of services;
3. Failure to obtain prior authorization for the service; or
4. Failure to meet timely filing requirements.

(3) (a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.
(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:
1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

(4) (a) A provider shall maintain a current health record for each recipient.
(b) 1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.
2. The individual who provided the service shall date and sign the health record within seventy-two (72) hours from the date that the individual provided the service.

(5) (a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.
(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(6) A provider shall comply with 45 C.F.R. Part 164.

Section 3. Covered Services.

(1) To be covered by the department, a service shall be:
  (a) Medically necessary;
  (b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
  (c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and
  (d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:
  (a) A service provided by a:
    1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;
    2. Locum tenens physician who provides direct physician contact;
    3. Physician assistant in accordance with Section 7 of this administrative regulation; or
    4. Locum tenens APRN who provides direct APRN contact;
  (b) A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;
  (c) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;
  (d) A sleep disorder service; or
  (e) A telehealth consultation provided in accordance with 907 KAR 3:170.

(3) A service provided by an other licensed medical professional shall be covered if the other licensed medical professional is:
  (a) Employed by the supervising physician; and
  (b) Licensed in the state of practice.

(4) A sleep disorder service shall be covered if performed in:
  (a) A hospital;
  (b) A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:
    1. American Sleep Disorders Association; or
    2. American Academy of Sleep Medicine; or
  (c) An independent diagnostic testing facility that:
    1. Is supervised by a physician trained in analyzing and interpreting sleep disorder recordings; and
    2. Has documentation demonstrating that it complies with criteria approved by the:
      a. American Sleep Disorders Association; or
      b. American Academy of Sleep Medicine.

Section 4. Service Limitations.

(1) A covered service provided to a lock-in recipient shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber unless:
  (a) The service represents emergency care; or

(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider.

(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034.

(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.

(4) An injectable drug listed on the Physician Injectable Drug List that is administered by a physician, APRN, or provider group shall be covered.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E (441.200 to 441.208) or Subpart F (441.250 to 441.259 and the Appendix to Subpart F), shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F.

(6) (a) Except as provided in paragraph (b) of this subsection, coverage for a service designated as a psychiatry service CPT code and provided by a physician shall be limited to four (4) services, per physician, per recipient, per twelve (12) months.

(b) Coverage for a service designated as a psychiatry service CPT code that is provided by a board certified or board eligible psychiatrist or by an advanced practice registered nurse with a specialty in psychiatry shall not be subject to the limits established in paragraph (a) of this subsection.

(c) Coverage for an evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service.

(d) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(7) An anesthesia service shall be covered if:

(a) Administered by:

1. An anesthesiologist who remains in attendance throughout the procedure; or
2. An individual who:
   a. Is licensed in Kentucky to practice anesthesia;
   b. Is licensed in Kentucky within his or her scope of practice; and
   c. Remains in attendance throughout the procedure;

(b) Medically necessary; and

(c) Not provided as part of an all-inclusive CPT code.

(8) The following shall not be covered:

(a) An acupuncture service;

(b) An autopsy;

(c) A cast or splint application in excess of the limits established in 907 KAR 3:010;

(d) Except for therapeutic bandage lenses, contact lenses;

(e) A hysterectomy performed for the purpose of sterilization;

(f) Lasik surgery;

(g) Paternity testing;

(h) A procedure performed for cosmetic purposes only;

(i) A procedure performed to promote or improve fertility;

(j) Radial keratotomy;

(k) A thermogram;

(l) An experimental service which is not in accordance with current standards of medical practice;
(m) A service which does not meet the requirements established in Section 3(1) of this administrative regulation;
(n) Medical direction of an anesthesia service; or
(o) Medical assistance for an other provider preventable condition in accordance with 907 KAR 14:005.

(9) (a) In accordance with 42 C.F.R. 455.410, to prescribe medication, order a service for a recipient, or refer a recipient for a service, a provider shall be currently enrolled and participating in the Medicaid program.
(b) The department shall not reimburse for a:
1. Prescription prescribed by a provider that is not currently:
a. Participating in the Medicaid program pursuant to 907 KAR 1:671; and
b. Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or
2. Service:
a. Ordered by a provider that is not currently:
(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and
(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or
b. Referred by a provider that is not currently:
(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and
(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672.

Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization.

(1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:
(a) Magnetic resonance imaging;
(b) Magnetic resonance angiogram;
(c) Magnetic resonance spectroscopy;
(d) Positron emission tomography;
(e) Cineradiography or videoradiography;
(f) Xeroradiography;
(g) Ultrasound subsequent to second obstetric ultrasound;
(h) Myocardial imaging;
(i) Cardiac blood pool imaging;
(j) Radiopharmaceutical procedures;
(k) Gastric restrictive surgery or gastric bypass surgery;
(l) A procedure that is commonly performed for cosmetic purposes;
(m) A surgical procedure that requires completion of a federal consent form; or
(n) A covered unlisted procedure or service.

(2) (a) Prior authorization by the department shall not be a guarantee of recipient eligibility.
(b) Eligibility verification shall be the responsibility of the provider.

(3) The prior authorization requirements established in subsection (1) of this section shall not apply to:
  (a) An emergency service;
  (b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or
  (c) A service provided to a recipient in an observation bed.

(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:
  (a) May request prior authorization from the department; and
  (b) If requesting prior authorization, shall request prior authorization by:
    1. Mailing or faxing:
      a. A written request to the department with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and
      b. If applicable, any required federal consent forms; or
    2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation.

Section 6. Therapy Service Limits.

(1) Speech-language pathology services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(2) Physical therapy services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(3) Occupational therapy services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(4) A service in excess of the limits established in subsection (1), (2), or (3) of this section shall be:
  (a) Prior authorized in accordance with subsection (5) of this section; and
  (b) Approved if the additional service is determined to be medically necessary by:
    1. The department, if the recipient is not enrolled with a managed care organization; or
    2. The managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

(5) Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsection (1), (2), or (3) of this section for a recipient who is not enrolled with a managed care organization.

Section 7. Physician Assistant Services.

(1) Except for a service limitation specified in subsection (2) or (3) of this section, a service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:
  (a) The service meets the requirements established in Section 3(1) of this administrative regulation;
  (b) The service is within the legal scope of certification of the physician assistant;

(c) The service is billed under the physician's individual provider number with the physician assistant's number included; and
(d) The physician assistant complies with:
1. KRS 311.840 to 311.862; and
2. If applicable, Section 2(1)(b) of this administrative regulation.

(2) A same service performed by a physician and either a physician assistant or an APRN on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:
(a) A physician noncovered service specified in Section 4(8) of this administrative regulation;
(b) An anesthesia service;
(c) An obstetrical delivery service; or
(d) A service provided in assistance of surgery.

Section 8. Behavioral Health Services Covered Pursuant to 907 KAR 15:010. The requirements and provisions established in 907 KAR 15:010 for a service covered pursuant to this administrative regulation and 907 KAR 15:010 shall apply if the service is provided by:

(1) A physician who is the billing provider;
(2) A provider group that is the billing provider; or
(3) A behavioral health practitioner under supervision who works for a:
(a) Physician who is the billing provider; or
(b) Provider group that is the billing provider.

Section 9. No Duplication of Service.

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

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physicians' services program.

Section 10. Third Party Liability. A provider shall comply with KRS 205.622.

Section 11. Use of Electronic Signatures.

(1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:
(a) Develop and implement a written security policy that shall:
1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;
(b) Develop a consent form that shall:
1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:
1. A copy of the provider's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 12. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 13. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 14. Appeal Rights. An appeal of a department decision regarding:
(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or
(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010.

Section 15. Incorporation by Reference.
(1) The "Physician Injectable Drug List", February 21, 2014, is incorporated by reference.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:
(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8:00 a.m. to 4:30 p.m.; or
(b) Online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm. (23 Ky.R. 1308; eff. 9-18-96; Am. 25 Ky.R. 1737; 2574; eff. 5-19-99; 30 Ky.R. 747; 1541; eff. 1-5-2004; 33 Ky.R. 617; 1405; 1585; eff. 1-5-07; 34 Ky.R. 451; 1474; eff. 1-4-2008; TAm eff. 4-28-2011; TAm eff. 7-16-2013; 40 Ky.R. 2002; 2540; 2759; eff. 7-7-2014; 41 Ky.R. 959; 1686; 1798; **eff. 3-6-2015.)**

Department for Medical Services - 907 KAR 3:010. Reimbursement for physicians' services.
www.lrc.ky.gov/kar/907/003/010.htm

RELATES TO: KRS 205.560, 42 C.F.R. 440.50, 447 Subpart B, 42 U.S.C. 1396a, b, c, d, s
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to

Kentucky's indigent citizenry. This administrative regulation establishes the method of reimbursement for physicians' services by the Medicaid Program.

Section 1. Definitions.

(1) "Add-on code" or "add-on service" means a service designated by a specific CPT code which may be used in conjunction with another CPT code to denote that an adjunctive service has been performed.
(2) "Assistant surgeon" means a physician who attends and acts as an auxiliary to a physician performing a surgical procedure.
(3) "Average wholesale price" or "AWP" means the average wholesale price published in a nationally-recognized comprehensive drug data file for which the department has contracted.
(4) "Biological" means the definition of "biologicals" pursuant to 42 U.S.C. 1395x(t)(1).
(5) "CPT code" means a code used for reporting procedures and services performed by physicians and published annually by the American Medical Association in Current Procedural Terminology.
(6) "Department" means the Department for Medicaid Services or its designee.
(7) "Drug" means the definition of "drugs" pursuant to 42 U.S.C. 1395x(t)(1).
(8) "Established patient" means one who has received professional services from the provider within the past three (3) year period.
(9) "Global period" means the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.
(10) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:
    (a) Requires few additional physician resources; or
    (b) Is clinically integral to the performance of the primary procedure.
(11) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.
(12) "Locum tenens" means a substitute physician:
    (a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and
    (b) Whose services are paid under the participating physician's provider number.
(13) "Major surgery" means a surgical procedure assigned a ninety (90) day global period.
(14) "Medicaid Physician Fee Schedule" means a list of current reimbursement rates for physician services established by the department in accordance with Section 3 of this administrative regulation.
(15) "Minor surgery" means a surgical procedure assigned a ten (10) day global period.
(16) "Modifier" means a reporting indicator used in conjunction with a CPT code to denote that a medical service or procedure that has been performed has been altered by a specific circumstance while remaining unchanged in its definition or CPT code.
(17) "Mutually exclusive" means that two (2) procedures:
    (a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;
    (b) Represent two (2) methods of performing the same procedure;
    (c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(18) "Physician assistant" is defined in KRS 311.840(3).

(19) "Physician group practice" means two (2) or more licensed physicians who have enrolled both individually and as a group and share the same Medicaid group provider number.

(20) "Professional component" means the physician service component of a service or procedure that has both a physician service component and a technical component.

(21) "Relative value unit" or "RVU" means the Medicare-established value assigned to a CPT code which takes into consideration the physician's work, practice expense and liability insurance.

(22) "Resource-based relative value scale" or "RBRVS" means the product of the relative value unit (RVU) and a resource-based dollar conversion factor.

(23) "Technical component" means the part of a medical procedure performed by a technician, inclusive of all equipment, supplies, and drugs used to perform the procedure.

(24) "Usual and customary charge" means the uniform amount which a physician charges the general public for a specific medical procedure or service.

Section 2. Reimbursement.

(1) Reimbursement for a covered service shall be made to:
   (a) The individual participating physician; or
   (b) A physician group practice enrolled in the Kentucky Medicaid Program.

(2) Except as provided in subsections (3) to (9) of this section, reimbursement for a covered service shall be the lesser of:
   (a) The physician's usual and customary charge; or
   (b) The amount specified in the Medicaid Physician Fee Schedule established in accordance with Section 3 of this administrative regulation.

(3) If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the usual and customary billed charge.

(4) Reimbursement for a service covered under Medicare Part B shall be made in accordance with 907 KAR 1:006, Section 3.

(5) If cost-sharing is required for a service to a recipient, the cost-sharing provisions established in 907 KAR 1:604 shall apply.

(6) Reimbursement for a service denoted by a modifier used in conjunction with a CPT code shall be as follows:
   (a) A second anesthesia service provided by a provider to a recipient on the same date of service and reported by the addition of the two (2) digit modifier twenty-three (23) shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable CPT code;
   (b) A professional component of a service reported by the addition of the two (2) digit modifier twenty-six (26) shall be reimbursed at the product of:
      1. The Medicare value assigned to the physician's work; and
      2. The dollar conversion factor specified in Section 3(2) of this administrative regulation;
   (c) A technical component of a service reported by the addition of the two (2) letter modifier "TC" shall be reimbursed at the product of:

1. The Medicare value assigned to the practice expense involved in the performance of the procedure; and
2. The dollar conversion factor specified in Section 3(2) of this administrative regulation;

(d) A bilateral procedure reported by the addition of the two (2) digit modifier fifty (50) shall be reimbursed at 150 percent of the amount assigned to the CPT code;

(e) An assistant surgeon procedure reported by the addition of the two (2) digit modifier eighty (80) shall be reimbursed at sixteen (16) percent of the allowable fee for the primary surgeon;

(f) A procedure performed by a physician acting as a locum tenens for a Medicaid-participating physician reported by the addition of the two (2) character modifier Q six (6) shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable CPT code;

(g) An evaluation and management telehealth consultation service provided by a consulting medical specialist in accordance with 907 KAR 3:170 and reported by the two (2) letter modifier "GT" shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable evaluation and management CPT code; and

(h) A level II National HCPCS (healthcare common procedure coding system) modifier designating a location on the body shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable code.

(7) Except for a service specified in paragraphs (a) or (b) of this subsection, a physician laboratory service shall be reimbursed in accordance with 907 KAR 1:028.

(a) Charges for a laboratory test performed by dipstick or reagent strip or tablet in a physician's office shall be included in the office visit charge.

(b) A routine venipuncture procedure shall not be separately reimbursed if submitted with a charge for an office, hospital or emergency room visit or in addition to a laboratory test.

(8) Reimbursement for placement of a central venous, arterial, or subclavian catheter shall be:

(a) Included in the fee for the anesthesia if performed by the anesthesiologist;

(b) Included in the fee for the surgery if performed by the surgeon; or

(c) Included in the fee for an office, hospital or emergency room visit if performed by the same provider.

(9) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5 p.m. Monday through Friday or beginning after 12 p.m. on Saturday or anytime Sunday.

Section 3. Reimbursement Methodology.

(1) Except for a service specified in subsections (3) through (7) of this section:

(a) The rate for a nonanesthesia related covered service shall be established by multiplying RVU by a dollar conversion factor to obtain the RBRVS maximum amount specified in the Medicaid Physician Fee Schedule; and

(b) The rate for a covered anesthesia service shall be established by multiplying the dollar conversion factor (designated as X) by the sum of each specific procedure code RVU (designated as Y) plus the number of units spent on that specific procedure (designated as Z). A unit shall equal a fifteen (15) minute increment of time.

(2) The dollar conversion factor shall be:

(a) Fifteen (15) dollars and twenty (20) cents for a nondelivery related anesthesia service; or

(b) Twenty-nine (29) dollars and sixty-seven (67) cents for all nonanesthesia related services.

(3) For the following services, reimbursement shall be the lesser of:
   (a) The actual billed charge;
   (b) A fixed fee of three (3) dollars and thirty (30) cents for:
      1. Administration of a pediatric vaccine to a Medicaid recipient under the age of twenty-one (21); or
      2. Administration of a flu vaccine;
   (c) For delivery-related anesthesia services, a fixed rate described as follows:
      1. Vaginal delivery, $215;
      2. Cesarean section, $335;
      3. Neuroxial labor anesthesia for a vaginal delivery or cesarean section, $350;
      4. Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for vaginal delivery shall be twenty-five (25) dollars;
      5. Additional anesthesia for cesarean hysterectomy following neuroxial labor anesthesia shall be twenty-five (25) dollars;
   (d) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70); or
   (e) A fixed rate of $150 for deep sedation or general anesthesia relating to oral surgery performed by an oral surgeon.

(4) Except as established in subsection (5) or (7)(c) of this section, the department shall reimburse the following drugs at the lesser of the average wholesale price (AWP) minus ten (10) percent or the actual bill charge, or the actual billed charge if the drug is administered in a physician's office.
   (a) Rho (D) immune globulin injection;
   (b) An injectable antineoplastic drug;
   (c) Medroxyprogesterone acetate for contraceptive use, 150 mg;
   (d) Penicillin G benzathine injection;
   (e) Ceftriaxone sodium injection;
   (f) Intravenous immune globulin injection;
   (g) Sodium hyaluronate or hylan G-F for intra-articular injection;
   (h) An intrauterine contraceptive device;
   (i) An implantable contraceptive device;
   (j) Long acting injectable risperidone; or
   (k) An injectable, infused or inhaled drug or biological that:
      1. Is not typically self-administered;
      2. Is not excluded as a noncovered immunization or vaccine; and
      3. Requires special handling, storage, shipping, dosing or administration.

(5) If long acting injectable risperidone is provided to an individual covered under both Medicaid and Medicare and administered by a physician employed by a community mental health center or other licensed medical professional employed by a community mental health center, the department shall provide reimbursement in an amount that is:
   (a) The same rate it reimburses for these drugs provided to Medicaid recipient; and
   (b) Reduced by the amount of the third party obligation.

(6) Reimbursement for a covered service provided by a physician assistant shall be:

(a) Made to the employing physician; or
(b) Included in the facility reimbursement if the physician assistant is employed by a primary care center, federally qualified health center, rural health clinic, or comprehensive care center.

(7) (a) Except for an item identified in paragraph (b) of this subsection or subsection (5) of this section, reimbursement for a service provided by a physician assistant shall be seventy-five (75) percent of the amount reimbursable to a physician in accordance with this section and Section 4 of this administrative regulation.

(b) Except as established in subsection (5) of this section, the department shall reimburse the following drugs at the lesser of the average wholesale price (AWP) minus ten (10) percent or the actual billed charge, if the drug is administered in a physician's office by a physician assistant:

1. Rho (D) immune globulin injection;
2. An injectable antineoplastic drug;
3. Medroxyprogesterone acetate for contraceptive use, 150 mg;
4. Penicillin G benzathine injection;
5. Ceftriaxone sodium injection;
6. Intravenous immune globulin injection;
7. Sodium hyaluronate or hylan G-F for intra-articular injection;
8. An intrauterine contraceptive device;
9. An implantable contraceptive device;
10. Long acting injectable risperidone; or
11. An injectable, infused or inhaled drug or biological:
    a. Is that not typically self-administered;
    b. Is not excluded as a noncovered immunization or vaccine; and
    c. Requires special handling, storage, shipping, dosing or administration.

Section 4. Reimbursement Limitations.

(1) (a) With the exception of chemotherapy administration to a recipient under the age of nineteen (19) years, reimbursement for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per twelve (12) months.

(b) Any claim for an evaluation and management service with a corresponding CPT code of 99214 or 99215 submitted in excess of the limit established in paragraph (a) of this subsection shall be reimbursed as an evaluation and management service with a corresponding CPT code of 99213.

(c) A claim for an evaluation and management service of moderate or high complexity in excess of the limit established in paragraph (a) of this subsection shall be reimbursed at the Medicaid rate for the evaluation and management service representing medical decision making of low complexity.

(2) Reimbursement for an anesthesia service shall include:
(a) Preoperative and postoperative visits;
(b) Administration of the anesthetic;
(c) Administration of fluids and blood incidental to the anesthesia or surgery;
(d) Postoperative pain management;

(e) Preoperative, intraoperative, and postoperative monitoring services; and
(f) Insertion of arterial and venous catheters.

(3) With the exception of an anesthetic, contrast, or neurolytic solution, administration of a substance by epidural or spinal injection for the control of chronic pain shall be limited to three (3) injections per six (6) month period per recipient.

(4) If related to the surgery and provided by the physician who performs the surgery, reimbursement for a surgical procedure shall include the following:
(a) A preoperative service;
(b) An intraoperative service;
(c) A postoperative service and follow-up care within:
1. Ninety (90) days following the date of major surgery; or
2. Ten (10) days following the date of minor surgery; and
(d) A preoperative consultation performed within two (2) days of the date of the surgery.

(5) Reimbursement for the application of a cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

(6) Reimbursement for the application of a cast or splint associated with a surgical procedure shall be considered to include:
(a) A temporary cast or splint, if applied by the same physician who performed the surgical procedure;
(b) The initial cast or splint applied during or following the surgical procedure; and
(c) A replacement cast or splint needed as a result of the surgical procedure if:
1. Provided within ninety (90) days of the procedure by the same physician; and
2. Applied for the same injury or condition.

(7) Multiple surgical procedures performed by a physician during the same operative session shall be reimbursed as follows:
(a) The major procedure, an add-on code, and other CPT codes approved by the department for billing with units shall be reimbursed in accordance with Section 3(1)(a) or (2)(b) of this administrative regulation; and
(b) The additional surgical procedure shall be reimbursed at fifty (50) percent of the amount determined in accordance with Section 3(1)(a) or (2)(b) of this administrative regulation.

(8) When performed concurrently, separate reimbursement shall not be made for a procedure that has been determined by the department to be incidental, integral, or mutually exclusive to another procedure.

(9) Reimbursement shall not be made for the cost of a vaccine that is administered by a physician.

Section 5. Supplemental Payments.

(1) In addition to a reimbursement made pursuant to Sections 2 through 4 of this administrative regulation, the department shall make a supplemental payment to a medical school faculty physician employed by a state-supported school of medicine that is part of a university health care system that includes a:
(a) Teaching hospital; and
(b) Pediatric teaching hospital.

(2) A supplemental payment plus other reimbursements made in accordance with this administrative regulation shall not exceed the physician's charge for the service provided and shall be paid directly or indirectly to the medical school.
(3) A supplemental payment made in accordance with this section shall be:
  (a) Based on the funding made available through an intergovernmental transfer of funds for this purpose by a state-supported school of medicine meeting the criteria established in subsection (1) of this section;
  (b) Consistent with the requirements of 42 C.F.R. 447.325; and
  (c) Made on a quarterly basis.

Section 6. Appeal Rights.
(1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.
(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.
(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671. (23 Ky.R. 1309; eff. 9-18-96; Am. 25 Ky.R. 1739; 2575; eff. 5-19-99; 27 Ky.R. 2596; eff. 5-14-2001; 28 Ky.R. 985; eff. 12-19-01; 30 Ky.R. 750; 1543; eff. 1-5-04; 31 Ky.R. 646; eff. 1-4-05; 33 Ky.R. 1180; 2322; eff. 3-9-07; 34 Ky.R. 456; 1045; 1478; eff. 1-4-2008; TAm. eff. 1-27-2012; TAm. **4-11-12**.)

Department for Medicaid Services - KRS 205.559. Requirements for Medicaid reimbursement to participating providers for telehealth consultations -- Report of impact on health care delivery system required -- Administrative regulations.

www.lrc.ky.gov/Statutes/statute.aspx?id=7707

(1) The Cabinet for Health and Family Services and any regional managed care partnership or other entity under contract with the cabinet for the administration or provision of the Medicaid program shall provide Medicaid reimbursement for a telehealth consultation that is provided by a Medicaid-participating practitioner who is licensed in Kentucky and that is provided in the telehealth network established in KRS 194A.125(3)(b).
(2) (a) The cabinet shall establish reimbursement rates for telehealth consultations. A request for reimbursement shall not be denied solely because an in-person consultation between a Medicaid-participating practitioner and a patient did not occur.
  (b) A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.
(3) A health-care facility that receives reimbursement under this section for consultations provided by a Medicaid-participating provider who practices in that facility and a health professional who obtains a consultation under this section shall establish quality-of-care protocols and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.

(4) The cabinet shall not require a telehealth consultation if an in-person consultation with a Medicaid-participating provider is reasonably available where the patient resides, works, or attends school or if the patient prefers an in-person consultation.

(5) The cabinet shall request any waivers of federal laws or regulations that may be necessary to implement this section.

(6) (a) The cabinet and any regional managed care partnership or other entity under contract with the cabinet for the administration or provision of the Medicaid program shall study the impact of this section on the health care delivery system in Kentucky and shall, upon implementation, issue a quarterly report to the Legislative Research Commission. This report shall include an analysis of:

1. The economic impact of this section on the Medicaid budget, including any costs or savings as a result of decreased transportation expenditures and office or emergency room visits;
2. The quality of care as a result of telehealth consultations rendered under this section; and
3. Any other issues deemed relevant by the cabinet.

(b) In addition to the analysis required under paragraph (a) of this subsection, the cabinet report shall compare telehealth reimbursement and delivery among all regional managed care partnerships or other entities under contract with the cabinet for the administration or provision of the Medicaid program.

(7) The cabinet shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms, records required, and authorization procedures to be followed in conjunction with this section.

Effective: June 26, 2007

History: Amended 2007 Ky. Acts ch. 24, sec. 26, effective June 26, 2007. – Amended 2005 Ky. Acts ch. 99, sec. 233, effective June 20, 2005. -- Created 2000 Ky. Acts ch. 376, sec. 4, effective July 15, 2001.

Legislative Research Commission Note (7/15/2001). Under 2000 Ky. Acts ch. 376, sec. 24(1), this statute takes effect "on July 15, 2001, or upon approval of any federal waivers, whichever first occurs." Because federal waivers were not approved, the effective date is July 15, 2001.

Department for Medicaid Services - 907 KAR 3:170. Telehealth consultation coverage of reimbursement. www.lrc.ky.gov/kar/907/003/170.htm

RELATES TO: KRS 194A.060, 194A.125, 205.510(15), 205.559, 205.560, 422.317, 434.840-434.860, 42 C.F.R. 415.174, 415.184, 431.300-431.307, 440.50

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559(2),(7), 205.560

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

telehealth providers and KRS 205.559(2) and (7) require the cabinet to promulgate an administrative regulation relating to telehealth consultations and reimbursement. This administrative regulation establishes the Department for Medicaid Services' coverage and reimbursement policies relating to telehealth consultations in accordance with KRS 205.559.

Section 1. Definitions.

(1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).
(2) "Certified nutritionist" is defined by KRS 310.005(12).
(3) "Chiropractor" is defined by KRS 312.015(3).
(4) "Community mental health center" or "CMHC" means a facility that provides a comprehensive range of mental health services to Medicaid recipients of a designated area in accordance with KRS 210.370 to 210.485.
(5) "Department" means the Department for Medicaid Services or its designated agent.
(6) "Diabetes self-management training consultation" means the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.
(7) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.
(8) "Encounter" means one (1) visit by a recipient to a telehealth spoke site where the recipient receives a telehealth consultation in real time, during the visit, from a telehealth provider or telehealth practitioner at a telehealth hub site.
(9) "Face-to-face" means, except as established in Section 4(4)(g) of this administrative regulation:
    (a) In person; and
    (b) Not via telehealth.
(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.
(11) "GT modifier" means a modifier that identifies a telehealth consultation which is approved by the healthcare common procedure coding system (HCPCS).
(12) "Health care provider" means a Medicaid provider who is:
    (a) Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and
    (b) Currently participating as a Medicaid provider in accordance with 907 KAR 1:671.
(13) "Hub site" means a telehealth site:
    (a) Where the telehealth provider or telehealth practitioner performs telehealth; and
    (b) That is considered the place of service.
(14) "Legally-authorized representative" means a Medicaid recipient's parent or guardian if a recipient is a minor child, or a person with power of attorney for a recipient.
(15) "Licensed clinical social worker" means an individual meeting the licensure requirements established in KRS 335.100.
(16) "Licensed dietitian" is defined by KRS 310.005(11).

(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).
(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).
(19) "Medical necessity" or "medically necessary" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(20) "National Provider Identifier" or "NPI" means a standard unique health identifier for health care providers which:
  (a) Is required by 42 C.F.R. 455.440; and
  (b) Meets the requirements of 45 C.F.R. 162.406.
(21) "Occupational therapist" is defined by KRS 319A.010(3).
(22) "Optometrist" means an individual licensed to engage in the practice of optometry in accordance with KRS 320.210(2).
(23) "Physical therapist" is defined by KRS 327.010(2).
(24) "Physician" is defined by KRS 311.550(12).
(25) "Physician assistant" is defined by KRS 311.840(3).
(26) "Psychologist" is defined by KRS 319.010(9).
(27) "Registered nurse" is defined by KRS 314.011(5).
(28) "Speech-language pathologist" is defined by KRS 33A.020(3).
(29) "Spoke site" means a telehealth site where the recipient receiving the telehealth consultation is located.
(30) "Telehealth consultation" is defined by KRS 205.510(15).
(31) "Telehealth practitioner" means an individual who is:
  (a) Authorized to perform a telehealth consultation in accordance with this administrative regulation;
  (b) Employed by or is an agent of a telehealth provider; and
  (c) Not the individual or entity who:
    1. Bills the department for a telehealth consultation; or
    2. Is reimbursed by the department for a telehealth consultation.
(32) "Telehealth provider" means a health care provider who:
  (a) Performs a telehealth consultation at a hub site; or
  (b) Is the employer of or entity that contracts with a telehealth practitioner who performs a telehealth consultation:
    1. At a hub site; and
    2. That is billed under the telehealth provider's national provider identifier.
(33) "Telehealth site" means a hub site or spoke site that has been approved as part of a telehealth network established in accordance with KRS 194A.125.
(34) "Telepresenter" means an individual operating telehealth equipment at a spoke site to enable a recipient to receive a telehealth consultation.

(35) "Transmission cost" means the cost of the telephone line and related costs incurred during the time of the transmission of a telehealth consultation.

(36) "Two (2) way interactive video" means a type of advanced telecommunications technology that permits a real time telehealth consultation to take place between a recipient and a telepresenter at the spoke site and a telehealth provider or telehealth practitioner at the hub site.

Section 2. General Policies.

(1) (a) Except as provided in paragraph (b) of this subsection, the coverage policies established in this administrative regulation shall apply to:

1. Medicaid services for individuals not enrolled in a managed care organization; and
2. A managed care organization's coverage of Medicaid services for individuals enrolled in the managed care organization for the purpose of receiving Medicaid or Kentucky Children's Health Insurance program services.

(b) A managed care organization shall not be required to reimburse the same amount for a telehealth consultation as the department reimburses, but may reimburse the same as the department reimburses if the managed care organization chooses to do so.

(2) A telehealth consultation shall not be reimbursed by the department if:

(a) It is not medically necessary;

(b) The equivalent service is not covered by the department if provided in a face-to-face setting;

(c) It requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371;

(d) The telehealth provider of the telehealth consultation is:

1. Not currently enrolled in the Medicaid program pursuant to 907 KAR 1:672;
2. Not currently participating in the Medicaid program pursuant to 907 KAR 1:671;
3. Not in good standing with the Medicaid program;
4. Currently listed on the Kentucky DMS List of Excluded Providers, which is available at http://chfs.ky.gov/dms/provEnr; or
5. Currently listed on the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities; which is available at https://oig.hhs.gov/exclusions/; or

(e) It is provided by a telehealth practitioner or telehealth provider not recognized or authorized by the department to provide the telehealth consultation or equivalent service in a face-to-face setting.

(3) (a) A telehealth provider shall:

1. Be an approved member of the Kentucky Telehealth Network; and
2. Comply with the standards and protocols established by the Kentucky Telehealth Board.

(b) To become an approved member of the Kentucky Telehealth Network, a provider shall:

1. Send a written request to the Kentucky Telehealth Board requesting membership in the

Kentucky Telehealth Network; and

2. Be approved by the Kentucky Telehealth Board as a member of the Kentucky Telehealth Network.

(4) (a) A telehealth consultation referenced in Section 3 or 4 of this administrative regulation shall be provided to the same extent and with the same coverage policies and restrictions that apply, except as established in Section 4(4)(g) and 4(5) of this administrative regulation to the equivalent service if provided in a face-to-face setting.

(b) If a telehealth coverage policy or restriction is not stated in this administrative regulation but is stated in another administrative regulation within Title 907 of the Kentucky Administrative Regulations, the coverage policy or restriction stated elsewhere within Title 907 of the Kentucky Administrative Regulations shall apply.

(5) (a) A telehealth consultation shall be subject to utilization review for:

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

(b) If the department determines that a telehealth consultation is not medically necessary, is not compliant with this administrative regulation, or is not compliant with applicable state or federal law, the department shall not reimburse for the telehealth consultation.

(c) If the department determines that a telehealth consultation that it has already reimbursed for was not medically necessary, was not compliant with this administrative regulation, or was not compliant with applicable state or federal law, the department shall recoup the reimbursement for the telehealth consultation from the provider.

(6) A telehealth consultation shall require:

(a) The use of two (2) way interactive video;

(b) A referral by a health care provider; and

(c) A referral by a recipient's lock-in provider if the recipient is locked in pursuant to:

1. 42 C.F.R. 431.54; and
2. 907 KAR 1:677.

Section 3. Telehealth Consultation Coverage in a Setting That is Not a Community Mental Health Center.

(1) The policies in this section shall apply to a telehealth consultation provided in a setting that is not a community mental health center.

(2) The following telehealth consultations shall be covered by the department as follows:

(a) A physical health evaluation and management consultation provided by:

1. A physician including a physician;
   a. With an individual physician practice;

b. Who belongs to a group physician practice; or
c. Who is employed by a federally-qualified health center, federally-qualified health center look-alike, rural health clinic, or primary care center;

2. An advanced practice registered nurse including an advanced practice registered nurse;
   a. With an individual advanced practice registered nurse practice;
   b. Who belongs to a group advanced practice registered nurse practice; or
   c. Who is employed by a physician, federally-qualified health center, federally-qualified health center look-alike, rural health clinic, or primary care center;
3. An optometrist; or
4. A chiropractor;

(b) A mental health evaluation and management service provided by:
1. A psychiatrist;
2. A physician in accordance with the limit established in 907 KAR 3:005;
3. An APRN in accordance with the limit established in 907 KAR 1:102;
4. A psychologist:
   a. With a license in accordance with KRS 319.010(6);
   b. With a doctorate degree in psychology;
   c. Who is directly employed by a psychiatrist; and
   d. If:
      (i) The psychiatrist by whom the psychologist is directly employed also interacts with the recipient during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psychologist is directly employed;
5. A licensed professional clinical counselor:
   a. Who is directly employed by a psychiatrist; and
   b. If:
      (i) The psychiatrist by whom the licensed professional clinical counselor is directly employed also interacts with the recipient during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed professional clinical counselor is directly employed;
6. A licensed clinical social worker:
   a. Who is directly employed by a psychiatrist; and
   b. If:
      (i) The psychiatrist by whom the licensed clinical social worker is directly employed also interacts with the recipient during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed clinical social worker is directly employed; or

7. A licensed marriage and family therapist:
   a. Who is directly employed by a psychiatrist; and
   b. If:
      (i) The psychiatrist by whom the licensed marriage and family therapist is directly employed also interacts with the recipient during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed marriage and family therapist is directly employed;

(c) Individual or group psychotherapy provided by:
1. A psychiatrist;
2. A physician in accordance with the limit established in 907 KAR 3:005;
3. An APRN in accordance with the limit established in 907 KAR 1:102;
4. A psychologist:
   a. With a license in accordance with KRS 319.010(6);
   b. With a doctorate degree in psychology;
   c. Who is directly employed by a psychiatrist; and
   d. If:
      (i) The psychiatrist by whom the psychologist is directly employed also interacts with the recipient or recipients during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psychologist is directly employed;
5. A licensed professional clinical counselor:
   a. Who is directly employed by a psychiatrist; and
   b. If:
      (i) The psychiatrist by whom the licensed professional clinical counselor is directly employed also interacts with the recipient or recipients during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed professional clinical counselor is directly employed;
6. A licensed clinical social worker:
   a. Who is directly employed by a psychiatrist; and
   b. If:
      (i) The psychiatrist by whom the licensed clinical social worker is directly employed also interacts with the recipient or recipients during the encounter; and
      (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed clinical social worker is directly employed; or
7. A licensed marriage and family therapist:
   a. Who is directly employed by a psychiatrist; and

b. If:
   (i) The psychiatrist by whom the licensed marriage and family therapist is directly employed also interacts with the recipient or recipients during the encounter; and
   (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed marriage and family therapist is directly employed;

(d) Pharmacologic management provided by:
   1. A physician in accordance with the limit established in 907 KAR 3:005;
   2. An APRN in accordance with the limit established in 907 KAR 1:102; or
   3. A psychiatrist;

(e) A psychiatric, psychological, or mental health diagnostic interview examination provided by:
   1. A psychiatrist;
   2. A physician in accordance with the limit established in 907 KAR 3:005;
   3. An APRN in accordance with the limit established in 907 KAR 1:102;
   4. A psychologist:
      a. With a license in accordance with KRS 319.010(6);
      b. With a doctorate degree in psychology;
      c. Who is directly employed by a psychiatrist; and
      d. If:
         (i) The psychiatrist by whom the psychologist is directly employed also interacts with the recipient during the encounter; and
         (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psychologist is directly employed;
   5. A licensed professional clinical counselor:
      a. Who is directly employed by a psychiatrist; and
      b. If:
         (i) The psychiatrist by whom the licensed professional clinical counselor is directly employed also interacts with the recipient during the encounter; and
         (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed professional clinical counselor is directly employed;
   6. A licensed clinical social worker:
      a. Who is directly employed by a psychiatrist; and
      b. If:
         (i) The psychiatrist by whom the licensed clinical social worker is directly employed also interacts with the recipient during the encounter; and
         (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed clinical social worker is directly employed; or

7. A licensed marriage and family therapist:
    a. Who is directly employed by a psychiatrist; and
    b. If:
        (i) The psychiatrist by whom the licensed marriage and family therapist is directly employed also interacts with the recipient during the encounter; and
        (ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the licensed marriage and family therapist is directly employed;

(f) Individual medical nutrition therapy consultation services provided by a:
1. Licensed dietitian:
    a. Who is directly employed by a physician, federally qualified health care center, rural health clinic, primary care center, a hospital's outpatient department, or the Department for Public Health; and
    b. If the telehealth consultation is billed under the:
        (i) NPI of the physician, federally qualified health care center, rural health clinic, hospital's outpatient department, or primary care center by whom the licensed dietitian is directly employed; or
        (ii) Department for Public Health if the licensed dietitian works for the Department for Public Health; or
2. Certified nutritionist:
    a. Who is directly employed by a physician, federally qualified health care center, rural health clinic, primary care center, a hospital's outpatient department, or the Department for Public Health ; and
    b. If the telehealth consultation is billed under the:
        (i) NPI of the physician, federally qualified health care center, rural health clinic, hospital's outpatient department, or primary care center by whom the certified nutritionist is directly employed; or
        (ii) Department for Public Health if the certified nutritionist works for the Department for Public Health;

(g) Individual diabetes self-management training consultation if:
1. Ordered by a:
    a. Physician;
    b. APRN directly employed by a physician; or
    c. Physician assistant directly employed by a physician;
2. Provided by a:
    a. Physician;
    b. APRN directly employed by a physician;
    c. Physician assistant directly employed by a physician;

d. Registered nurse directly employed by a physician; or
e. Licensed dietitian directly employed by a physician, federally qualified health care center, rural health clinic, primary care center, a hospital's outpatient department, or the Department for Public Health; and

3. The telehealth consultation is billed under the:
   a. NPI of the physician, federally qualified health care center, rural health clinic, hospital's outpatient department**,** or primary care center by whom the provider is directly employed; or
   b. Department for Public Health if the provider works for the Department for Public Health;

(h) An occupational therapy evaluation or treatment provided by an occupational therapist who is directly employed by a physician:
1. If direct physician contact occurs during the evaluation;
2. If the telehealth consultation is billed under the physician's NPI; and
3. In accordance with the limits established in 907 KAR 3:005;

(i) An occupational therapy evaluation or treatment provided by an occupational therapist who is directly employed by or is an agent of a nursing facility:
1. If the telehealth consultation is billed under the nursing facility's NPI; and
2. In accordance with the limits established in 907 KAR 1:065;

(j) An occupational therapy evaluation or treatment provided by an occupational therapist who is directly employed by or is an agent of a home health agency:
1. If the telehealth consultation is billed under the home health agency's NPI; and
2. In accordance with the limits established in 907 KAR 1:030;

(k) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by a physician:
1. If direct physician contact occurs during the evaluation;
2. If the telehealth consultation is billed under the physician's NPI; and
3. In accordance with the limits established in 907 KAR 3:005;

(l) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by or is an agent of a hospital's outpatient department:
1. If the telehealth consultation is billed under the hospital's outpatient department's NPI; and
2. In accordance with the limits established in 907 KAR 10:014;

(m) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by or is an agent of a home health agency:
1. If the telehealth consultation is billed under the home health agency's NPI; and
2. In accordance with the limits established in 907 KAR 1:030;

(n) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by or is an agent of a nursing facility:
   1. If the telehealth consultation is billed under the nursing facility's NPI; and
   2. In accordance with the limits established in 907 KAR 1:065;

(o) A speech therapy evaluation or treatment provided by a speech-language pathologist who is directly employed by a physician:
   1. If direct physician contact occurs during the evaluation or treatment;
   2. If the telehealth consultation is billed under the physician's NPI; and
   3. In accordance with the limits established in 907 KAR 3:005;

(p) A speech therapy evaluation or treatment provided by a speech-language pathologist who is directly employed by or is an agent of a hospital's outpatient department:
   1. If the telehealth consultation is billed under the hospital's outpatient department's NPI; and
   2. In accordance with the limits established in 907 KAR 10:014;

(q) A speech therapy evaluation or treatment provided by a speech-language pathologist who is directly employed by or is an agent of a home health agency:
   1. If the telehealth consultation is billed under the home health agency's NPI; and
   2. In accordance with the limits established in 907 KAR 1:030;

(r) A speech therapy evaluation or treatment provided by a speech-language pathologist who is directly employed by or is an agent of a nursing facility:
   1. If the telehealth consultation is billed under the nursing facility's NPI; and
   2. In accordance with the limits established in 907 KAR 1:065;

(s) A neurobehavioral status examination provided by:
   1. A psychiatrist;
   2. A physician in accordance with the limit established in 907 KAR 3:005; or
   3. A psychologist:
      a. With a license in accordance with KRS 319.010(6);
      b. With a doctorate degree in psychology; and
      c. Who is directly employed by a physician or a psychiatrist:
         (i) In accordance with the limits established in 907 KAR 3:005;
         (ii) If the physician or psychiatrist by whom the psychologist is directly employed also interacts with the recipient during the encounter; and
         (iii) If the telehealth consultation is billed under the NPI of the physician or psychiatrist by whom the psychologist is directly employed; or

(t) End-stage renal disease monitoring, assessment, or counseling consultations for home dialysis recipient provided by:
   1. A physician directly employed by a hospital's outpatient department if the telehealth

consultation is billed under the hospital's outpatient department's NPI; or

2. An APRN directly employed by a hospital's outpatient department if the telehealth consultation is billed under the hospital's outpatient department's NPI.

Section 4. Telehealth Consultation Coverage in a Community Mental Health Center

(1) The policies in this section shall apply to a tele-health consultation provided via a community mental health center.

(2) The limits, restrictions, exclusions, or policies:

(a) Which apply to a service provided face-to-face in a community mental health center shall apply to a telehealth consultation or service provided via telehealth via a community mental health center; and

(b) Established in 907 KAR 1:044 shall apply to a telehealth consultation or service provided via:

1. Telehealth; and
2. A community mental health center.

(3) The department shall not reimburse for a telehealth consultation provided via a community mental health center if:

(a) The consultation is not billed under the community mental health center's national provider identifier; or

(b) The person who delivers the telehealth consultation is not**:**

1. Directly employed by the community mental health center; or
2. An agent of a community mental health center.

(4) The following telehealth consultations provided via a community mental health center shall be covered by the department as follows:

(a) A psychiatric diagnostic interview examination provided:

1. In accordance with 907 KAR 1:044; and
2. By:
   a. A psychiatrist; or
   b. An APRN who:
      (i) Is certified in the practice of psychiatric mental health nursing; and
      (ii) Meets the requirements established in 201 KAR 20:057;

(b) A psychological diagnostic interview examination provided:

1. In accordance with 907 KAR 1:044; and
2. By:
   a. A psychiatrist; or
   b. A psychologist with a license in accordance with KRS 319.010(6);

(c) Pharmacologic management provided:

1. In accordance with 907 KAR 1:044; and

2. By:
    a. A physician;
    b. A psychiatrist; or
    c. An APRN who:
        (i) Is certified in the practice of psychiatric mental health nursing; and
        (ii) Meets the requirements established in 201 KAR 20:057**;**

(d) Group psychotherapy provided:
1. In accordance with 907 KAR 1:044; and
2. By:
    a. A psychiatrist;
    b. A psychologist with a license in accordance with KRS 319.010(6);
    c. A licensed professional clinical counselor;
    d. A licensed marriage and family therapist;
    e. A licensed clinical social worker;
    f. A psychiatric registered nurse; or
    g. An APRN who:
        (i) Is certified in the practice of psychiatric mental health nursing; and
        (ii) Meets the requirements established in 201 KAR 20:057;

(e) Mental health evaluation and management emergency services provided:
1. In accordance with 907 KAR 1:044; and
2. By:
    a. A psychiatrist;
    b. A psychologist with a license in accordance with KRS 319.010(6);
    c. A licensed professional clinical counselor;
    d. A licensed marriage and family therapist;
    e. A licensed clinical social worker;
    f. A psychiatric medical resident;
    g. A psychiatric registered nurse; or
    h. An APRN who:
        (i) Is certified in the practice of psychiatric mental health nursing; and
        (ii) Meets the requirements established in 201 KAR 20:057;

(f) A mental health assessment provided:
1. In accordance with 907 KAR 1:044; and
2. By a psychologist with a license in accordance with KRS 319.010(6); or

(g) Individual psychotherapy provided:
1. In accordance with 907 KAR 1:044 except that “face-to-face” shall include two (2) way interactive video for the purpose of individual psychotherapy provided via a community

mental health center; and

2. By:
   a. A psychiatrist;
   b. A psychologist with a license in accordance with KRS 319.010(6);
   c. A licensed professional clinical counselor;
   d. A licensed marriage and family therapist;
   e. A licensed clinical social worker;
   f. A psychiatric registered nurse; or
   g. An APRN who:
      (i) Is certified in the practice of psychiatric mental health nursing; and
      (ii) Meets the requirements established in 201 KAR 20:057.

(5) If a provision established in 907 KAR 1:044 or the material incorporated by reference into 907 KAR 1:044 is in contrast with subsection (4)(g)1. of this section, the policy established in subsection (4)(g)1 of this section shall supersede the contrary statement.

Section 5. Reimbursement

(1) (a) The department shall reimburse a telehealth provider who is eligible for reimbursement from the department for a telehealth consultation an amount equal to the amount paid for a comparable in-person service in accordance with:
   1. 907 KAR 3:010 if the service was provided:
      a. By a physician; and
      b. Not in the circumstances described in subparagraphs 3., 4., 5., or 6. of this paragraph;
   2. 907 KAR 1:104 if the service was provided:
      a. By an advanced practice registered nurse; and
      b. Not in the circumstances described in subparagraphs 3., 4., 5., or 6. of this paragraph;
   3. 907 KAR 1:055 if the service was provided and billed through a federally-qualified health center, federally-qualified health center look-alike, rural health clinic, or primary care center.
   4. 907 KAR 1:015 if the service was provided and billed through a hospital outpatient department;
   5. 907 KAR 1:031 if the service was provided and billed through a home health agency; or
   6. 907 KAR 1:065 if the service was provided and billed through a nursing facility.

   (b) 1. Reimbursement for a telehealth consultation provided by a practitioner who is employed by a provider or is an agent of a provider shall be a matter between the provider and the practitioner.
   2. The department shall not be liable for reimbursing a practitioner who is employed by a

provider or is an agent of a provider.

(c) A managed care organized shall not be required to reimburse the same amount for a telehealth consultation as the department reimburses, but may reimburse the same amount as the department reimburses if the managed care organization chooses to do so.

(2) A telehealth provider shall bill for a telehealth consultation using the appropriate two (2) letter "GT" modifier.

(3) The department shall not require the presence of a health care provider requesting a telehealth consultation at the time of the telehealth consultation unless it is requested by a telehealth provider or telehealth practitioner at the hub site.

(4) The department shall not reimbursement for transmission costs.

Section 6. Confidentiality and Data Integrity

(1) A telehealth consultation shall be performed on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth consultation information.

(2) Both a hub site and a spoke site shall use authentication and identification to ensure the confidentiality of a telehealth consultation.

(3) A telehealth provider of a telehealth practitioner of a telehealth consultation shall implement confidentiality protocols that include:

(a) Identifying personnel who have access to a telehealth transmission;

(b) Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission; and

(c) Preventing unauthorized access to a telehealth transmission.

(4) A telehealth provider's or telehealth practitioner's protocols and guidelines shall be available for inspection by the department upon request.

Section 7. Informed Consent

(1) Before providing a telehealth consultation to a recipient, a telehealth provider or telehealth practitioner shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:

(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;

(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consultation shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R. Parts 160, 162, 164, KRS 205.566, 216.2927, and any other federal law or regulation or state law establishing individual health care data confidentiality policies;

(e) The recipient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consultation and shall have the right to exclude anyone from either site; and

(f) The recipient shall have the right to object to the video taping of a telehealth consultation.

(2) A copy of the signed informed consent shall be retained in the recipient's medical record and provided to the recipient or the recipient's legally-authorized representative upon request.

(3) The requirement to obtain informed consent before providing a telehealth consultation shall not apply to an emergency situation if the recipient is unable to provide informed consent and the recipient's legally-authorized representative is unavailable.

Section 8. Medical Records

(1) A request for a telehealth consultation from a health care provider and the medical necessity for the telehealth consultation shall be documented in the recipient's medical record.

(2) A health care provider shall keep a complete medical record of a telehealth consultation provided to a recipient and follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality in accordance with KRS 194A.060, 422.317, 434.840 - 434.860, 42 C.F.R. 431.300 to 431.307, and 45 C.F.R. 164.530(j).

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

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

(4) Documentation of a telehealth consultation by the referring health care provider shall be included in the recipient's medical record and shall include:

(a) The diagnosis and treatment plan resulting from the telehealth consultation and a progress note by the referring health care provider if present at the spoke site during the telehealth consultation;

(b) The location of the hub site and spoke site;

(c) A copy of the document signed by the recipient indicating the recipient’s informed consent to the telehealth consultation;

(d) Documentation supporting the medical necessity of the telehealth consultation; and

(e) The referral order and complete information from the referring health care provider who

requested the telehealth consultation for the recipient.

(5) (a) A telehealth provider's or telehealth practitioner's diagnosis and recommendations resulting from a telehealth consultation shall be documented in the recipient's medical record at the office of the health care provider who requested the telehealth consultation.

(b) Except as established in paragraph (c) of this subsection, a telehealth provider or telehealth practitioner shall send a written report regarding a telehealth consultation within thirty (30) days of the consultation to the referring health care provider.

(c) If a community mental health center was the referring health care provider and the provider of the telehealth consultation for a recipient, the requirement in paragraph (b) of this subsection shall not apply.

Section 9. Federal Financial Participation

A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

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

(2) Disapproves the policy.

Section 10: Appeal Rights

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

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

(3) A provider may appeal a department-written determination as to the application of this administrative regulation in accordance with 907 KAR 1:671. (28 Ky.R. 150, Am. 1430; eff. 12-19-2001; 30 Ky.R. 1861; 2055; eff. 3-18-2004; 32 Ky.R. 1934; 2279; eff. 7-7-2006; 35 Ky.R. 1923; 2456; 2757; eff. 7-6-2009; 39 Ky.R. 1070; 1738; 2036; **eff. 5-3-2013**.)

Department for Medicaid Services - 907 KAR 9:005. Non-outpatient level I and II psychiatric residential treatment facility service and coverage policies.

www.lrc.ky.gov/kar/907/009/005.htm

RELATES TO: KRS 205.520, 216B.450, 216B.455, 216B.459

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.160, 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This

administrative regulation establishes Medicaid program coverage policies regarding Level I and Level II psychiatric residential treatment facility services that are not provided on an outpatient basis.

Section 1. Definitions.

(1) "Active treatment" means a covered Level I or II psychiatric residential treatment facility service provided:
  (a) In accordance with an individual plan of care as specified in 42 C.F.R. 441.154; and
  (b) By an individual employed or contracted by a Level I or II PRTF including a:
    1. Qualified mental health personnel;
    2. Qualified mental health professional;
    3. Mental health associate; or
    4. Direct care staff person.

(2) "Acute care hospital" is defined by KRS 205.639(1).

(3) “Advanced practice registered nurse” is defined by KRS 314.011(7).

(4) "Behavioral health professional" means:
  (a) A psychiatrist;
  (b) A physician licensed in Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties;
  (c) A licensed psychologist;
  (d) A licensed psychological practitioner;
  (e) A licensed clinical social worker;
  (f) An advanced practice registered nurse;
  (g) A licensed marriage and family therapist;
  (h) A licensed professional clinical counselor;
  (i) A licensed professional art therapist;
  (j) A licensed clinical alcohol and drug counselor in accordance with Section 13 of this administrative regulation;
  (k) A certified psychologist with autonomous functioning; or
  (l) A certified alcohol and drug counselor.

(5) "Behavioral health professional under clinical supervision" means:
  (a) A certified psychologist;
  (b) A licensed psychological associate;
  (c) A marriage and family therapist associate;
  (d) A certified social worker;
  (e) A licensed professional counselor associate;
  (f) A licensed professional art therapist associate;
  (g) A physician assistant, or
  (h) A licensed clinical alcohol and drug counselor associate in accordance with Section 13 of this administrative regulation.

(6) “Certified alcohol and drug counselor” means an individual who meets the requirements in KRS 309.083.

(7) “Certified psychologist” means an individual who is a certified psychologist pursuant o KRS 319.056.

(8) “Certified psychologist with autonomous functioning” means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.
(9) “Certified social worker” means an individual who meets the requirements established in KRS 335.080.
(10) "Child with a severe emotional disability" is defined by KRS 200.503(2).
(11) "Department" means the Department for Medicaid Services or its designee.
(12) "Diagnostic and assessment services" means at least one (1) face-to-face specialty evaluation or specialty evaluation performed via telemedicine of a recipient’s medical, social, and psychiatric status provided by a physician or qualified mental health professional that shall:
    (a) Include:
        1. Interviewing and evaluating; or
        2. Testing;
    (b) Be documented and record all contact with the recipient and other interviewed individuals; and
    (c) Result in a:
        1. Medical data code in accordance with 45 C.F.R. 162.1000; and
        2. Specific treatment recommendation.
(13) “Enrollee” means a recipient who is enrolled with a managed care organization.
(14) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(15) "Intensive treatment services" means a program:
    (a) For a child:
        1. With a severe emotional disability; and
            a. An intellectual disability;
            b. A severe and persistent aggressive behavior;
            c. Sexually acting out behavior; or
            d. A developmental disability;
        2. Who requires a treatment-oriented residential environment; and
        3. Between the ages of four (4) to twenty-one (21) years; and
    (b) That provides psychiatric and behavioral health services two (2) or more times per week to a child referenced in paragraph (a) of this subsection:
        1. As indicated by the child’s psychiatric and behavioral health needs; and
        2. In accordance with the child’s therapeutic plan of care.
(16) "Interdisciplinary team" means:
    (a) For a recipient who is under the age of eighteen (18) years:
        1. A parent, legal guardian, or caregiver of the recipient;
        2. The recipient;
        3. A qualified mental health professional; and
        4. A staff person, if available, who worked with the recipient during the recipient’s most recent placement if the recipient has previously been in a Level I or II PRTF; or
    (b) For a recipient who is eighteen (18) years of age or older:
        1. The recipient;
        2. A qualified mental health professional;

3. A staff person, if available, who worked with the recipient during the recipient's most recent placement if the recipient has previously been in a Level I or II PRTF; and
4. If requested by the recipient, a parent, legal guardian, or caregiver of the recipient.

(17) "Level I PRTF" means a psychiatric residential treatment facility that meets the criteria established in KRS 216B.450(5)(a).

(18) "Level II PRTF" means a psychiatric residential treatment facility that meets the criteria established in KRS 216B.450(5)(b).

(19) "Licensed clinical alcohol and drug counselor" is defined by KRS 309.080(4).

(20) "Licensed clinical alcohol and drug counselor associate" is defined by KRS 309.080(5).

(21) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(22) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(23) "Licensed professional art therapist" is defined by KRS 309.130(2).

(24) "Licensed professional art therapist associate" is defined by KRS 309.130(3).

(25) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(26) "Licensed professional counselor associate" is defined by KRS 335.500(4).

(27) "Licensed psychological associate" means an individual who:
(a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and
(b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(28) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(29) "Licensed psychologist" means an individual who:
(a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and
(b) Meets the licensed psychologist requirements established in 201 Chapter 26.

(30) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(31) "Medicaid payment status" means a circumstance in which:
(a) The person:
1. Is eligible for and receiving Medicaid benefits; and
2. Meets patient status criteria for Level I or II psychiatric residential treatment facility services; and
(b) The facility is billing the Medicaid program for services provided to the person.

(32) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(33) "Mental health associate" means:
(a) 1. An individual with a minimum of a bachelor's degree in a mental health related field;
2. A registered nurse; or
3. A licensed practical nurse with at least one (1) year experience in a psychiatric inpatient or residential treatment setting for children; or
(b) An individual with:
1. A high school diploma or an equivalence certificate; and
2. At least two (2) years work experience in a psychiatric inpatient or residential treatment setting for children.

(34) "Physician" is defined by KRS 205.510(11).
(35) “Physician assistant” is defined by KRS 311.840(3).
(36) “Private psychiatric hospital” is defined by KRS 205.639(2).
(37) “Provider” is defined by KRS 205.8451(7).
(38) “Provider abuse” is defined by KRS 205.8451(8).
(39) "Psychiatric residential treatment facility" or "PRTF" is defined by KRS 216B.450(5).
(40) "Psychiatric services" means:
    (a) An initial psychiatric evaluation of a recipient which shall include:
        1. A review of the recipient’s:
            a. Personal history;
            b. Family history;
            c. Physical health;
            d. Prior treatment; and
            e. Current treatment;
        2. A mental status examination appropriate to the age of the recipient;
        3. A meeting with the family or any designated significant person in the recipient’s life; and
        4. Ordering and reviewing:
            a. Laboratory data;
            b. Psychological testing results; or
            c. Any other ancillary health or mental health examinations;
    (b) Development of an initial plan of treatment which shall include:
        1. Prescribing and monitoring of psychotropic medications; or
        2. Providing and directing therapy to the recipient;
    (c) Implementing, assessing, monitoring, or revising the treatment as appropriate to the recipient’s psychiatric status;
    (d) Providing a subsequent psychiatric evaluation as appropriate to the recipient’s psychiatric status;
    (e) Consulting, if determined to be necessary by the psychiatrist responsible for providing or overseeing the recipient’s psychiatric services, with another physician, an attorney, or the police regarding the recipient’s care and treatment; or
    (f) Ensuring that the psychiatrist responsible for providing or overseeing the recipient’s psychiatric services has access to the information resulting from or related to any consultation referenced in paragraph (e) of this subsection.
(41) "Qualified mental health personnel" is defined by KRS 216B.450(6).
(42) "Qualified mental health professional" is defined by KRS 216B.450(7).
(43) “Recipient” is defined by KRS 205.8451(9).
(44) “Recipient abuse” is defined by KRS 205.8451(10).
(45) “Review agency” means, for a review, evaluation, or authorization decision regarding an individual who is:
    (a) Not enrolled with a managed care organization:
        1. The department; or
        2. An entity under contract with the department; or
    (b) Enrolled with a managed care organization:

1. The managed care organization with which the enrollee is enrolled; or
2. An entity under contract with the managed care organization with which the enrollee is enrolled.

(46) "State mental hospital" is defined by KRS 205.639(3).

(47) "Telemedicine" means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

(48) "Treatment plan" means a plan created for the care and treatment of a recipient that:

(a) Is developed in a face-to-face meeting by the recipient's interdisciplinary team;

(b) Describes a comprehensive, coordinated plan of medically necessary behavioral health services that specifies a modality, frequency, intensity, and duration of services sufficient to maintain the recipient in a PRTF setting; and

(c) Identifies:

1. A program of therapies, activities, interventions, or experiences designed to accomplish the plan;
2. A qualified mental health professional, a mental health associate, or qualified mental health personnel who shall manage the continuity of care;
3. Interventions by caregivers in the PRTF and school setting that support the recipient's ability to be maintained in a PRTF setting;
4. Behavioral, social, and physical problems with interventions and objective, measurable goals;
5. Discharge criteria that specifies the:
   a. Recipient-specific behavioral indicators for discharge from the service;
   b. Expected service level that would be required upon discharge; and
   c. Identification of the intended provider to deliver services upon discharge;
6. A crisis action plan that progresses through a continuum of care that is designed to reduce or eliminate the necessity of inpatient services;
7. A plan for:
   a. Transition to a lower intensity of services; and
   b. Discharge from PRTF services;
8. An individual behavior management plan;
9. A plan for the involvement and visitation of the recipient with the birth family, guardian, or other significant person, unless prohibited by a court, including therapeutic off-site visits pursuant to the treatment plan; and
10. Services and planning, beginning at admission, to facilitate the discharge of the recipient to an identified plan for home-based services or a lower level of care.

Section 2. Provider Participation.

(1) (a) In order to participate, or continue to participate, in the Kentucky Medicaid Program, a Level I PRTF shall:

1. Have a utilization review plan for each recipient consisting of, at a minimum, a pre-admission certification review submitted via telephone or electronically to the review agency prior to admission of the recipient;
2. Perform and place in each recipient's record:
   a. A medical evaluation;
   b. A social evaluation; and
   c. A psychiatric evaluation;
3. Establish a plan of care for each recipient which shall be placed in the recipient's record;
4. Appoint a utilization review committee which shall:
   a. Oversee and implement the utilization review plan; and
   b. Evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;
5. Comply with staffing requirements established in 902 KAR 20:320;
6. Be located in the Commonwealth of Kentucky;
7. Maintain accreditation by the Joint Commission on Accreditation of Health Care Organizations or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that is recognized by the state; and
8. Comply with all conditions of Medicaid provider participation established in 907 KAR 1:671 and 907 KAR 1:672.

(b) In order to participate, or continue to participate, in the Kentucky Medicaid Program, a Level II PRTF shall:
1. Have a utilization review plan for each recipient;
2. Establish a utilization review process which shall evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;
3. Comply with staffing requirements established in 902 KAR 20:320;
4. Be located in the Commonwealth of Kentucky;
5. Maintain accreditation by the Joint Commission on Accreditation of Health Care Organizations or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that is recognized by the state;
6. Comply with all conditions of Medicaid provider participation established in 907 KAR 1:671 and 907 KAR 1:672;
7. Perform and place in each recipient's record a:
   a. Medical evaluation;
   b. Social evaluation; and
   c. Psychiatric evaluation; and
8. Establish a plan of care for each recipient which shall:
   a. Address in detail the intensive treatment services to be provided to the recipient; and
   b. Be placed in the recipient's record.

(2) (a) A pre-admission certification review for a Level I PRTF shall:
1. Contain:
   a. The recipient's valid Medicaid identification number;

b. For a recipient who is not enrolled with a managed care organization, a valid MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21) which satisfies the requirements of 42 C.F.R. 44.152 and 42 C.F.R. 441.153 for patients age twenty-one (21) and under;
c. A DMS-IV R diagnosis on all five (5) axes, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for Level I PRTF treatment;
d. A description of the initial treatment plan relating to the admitting symptoms;
e. Current symptoms requiring inpatient treatment;
f. Information to support the medical necessity and clinical appropriateness of the services or benefits of the admission to a Level I PRTF in accordance with 907 KAR 3:130;
g. Medication history;
h. Prior hospitalization;
i. Prior alternative treatment;
j. Appropriate medical, social, and family histories; and
k. Proposed aftercare placement;

2. Remain in effect for the days certified by the review agency; and
3. Be completed within thirty (30) days.

(b) A pre-admission certification review for a Level II PRTF for a non-emergent admission shall:

1. Contain:
   a. The recipient's valid Medicaid identification number;
   b. For a recipient who is not enrolled with a managed care organization, a valid MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21) which satisfies the requirements of 42 C.F.R. 44.152 and 42 C.F.R. 441.153 for patients age twenty-one (21) and under;
   c. A DSM-IV-R diagnosis on all five (5) axes, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for Level II PRTF treatment;
   d. A description of the initial treatment plan relating to the admitting symptoms;
   e. Current symptoms requiring inpatient treatment;
   f. Information to support the medical necessity and clinical appropriateness of the services or benefits of the admission to a Level II PRTF in accordance with 907 KAR 3:130;
   g. Medication history;
   h. Prior hospitalization;
   i. Prior alternative treatment;
   j. Appropriate medical, social, and family histories; and
   k. Proposed aftercare placement;
2. Remain in effect for the days certified by the review agency; and
3. Be completed within thirty (30) days.

(3) Failure to admit a recipient within the recipient's certification period shall require a new pre-admission certification review request.

(4) A utilization review plan for an emergency admission to a Level II PRTF shall contain:

(a) For a recipient who is not enrolled with a managed care organization, a completed MAP-570, Medicaid Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21):

1. Completed by the facility's interdisciplinary team; and
2. Placed in the recipient's medical record;

(b) Documentation, provided by telephone or electronically to the review agency within two (2) days of the recipient's emergency admission, justifying:

1. The recipient's emergency admission;
2. That ambulatory care resources in the recipient's community and placement in a Level I PRTF do not meet the recipient's needs;
3. That proper treatment of the recipient's psychiatric condition requires services provided by a Level II PRTF under the direction of a physician; and
4. That the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services are no longer needed;

(c) The recipient's valid Medicaid identification number;

(d) For a recipient who is not enrolled with a managed care organization, a valid MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21), which satisfies the requirements of 42 C.F.R. 441.152 and 42 C.F.R. 441.153 for recipients age twenty-one (21) and under;

(e) A DMS-IV-R diagnosis on all five (5) axes, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for Level II PRTF treatment;

(f) 1. A description of the initial treatment plan relating to the admitting symptom; and
2. As part of the initial treatment plan, a full description of the intensive treatment services to be provided to the recipient;

(g) Current symptoms requiring residential treatment;

(h) Medication history;

(i) Prior hospitalization;

(j) Prior alternative treatment;

(k) Appropriate medical, social, and family histories; and

(l) Proposed aftercare placement.

(5) For an individual who becomes Medicaid eligible after admission and who is not enrolled with a managed care organization, a Level I or II PRTF's interdisciplinary team shall complete a MAP-570, Medicaid Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21), and the form shall be placed in the recipient's medical record.

(6) For a recipient, a Level I or II PRTF shall maintain medical records that shall:

(a) Be:

1. Current;
2. Readily retrievable;

3. Organized;
4. Complete; and
5. Legible;

(b) Reflect sound medical recordkeeping practice in accordance with:
1. 902 KAR 20:320;
2. KRS 194A.060;
3. KRS 434.840 through 860;
4. KRS 422.317; and
5. 42 C.F.R. 431 Subpart F;

(c) Document the need for admission and appropriate utilization of services;

(d) Be maintained, including information regarding payments claimed, for a minimum of six (6) years or until an audit dispute or issue is resolved, whichever is longer; and

(e) Be made available for inspection or copying or provided to the following upon request:
1. A representative of the United States Department for Health and Human Services or its designee;
2. The United States Office of the Attorney General or its designee;
3. The Commonwealth of Kentucky, Office of the Attorney General or its designee;
4. The Commonwealth of Kentucky, Office of the Auditor of Public Accounts or its designee;
5. The Commonwealth of Kentucky, Cabinet for Health and Family Services, Office of the Inspector General or its designee;
6. The department; or
7. A managed care organization with whom the department has contracted if the recipient is enrolled with the managed care organization.

(7) (a) If a Level I or Level II psychiatric residential treatment facility receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the Level I or Level II psychiatric residential treatment facility shall return the payment to the department or managed care organization that issued the duplicate payment or overpayment in accordance with 907 KAR 1:671.

(b) Failure to return a payment to the department or managed care organization in accordance with paragraph (a) of this subsection may be:
1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

(8) (a) When the department or managed care organization makes payment for a covered service and the Level I and Level II psychiatric residential treatment facility accepts the payment:
1. The payment shall be considered payment in full;
2. A bill for the same service shall not be given to the recipient; and
3. Payment from the recipient for the same service shall not be accepted by the Level I or Level II psychiatric residential treatment facility.

(b) 1. A Level I or Level II psychiatric residential treatment facility may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:
a. Recipient requests the service; and
b. Level I or Level II psychiatric residential treatment facility makes the recipient aware in advance of providing the service that the:

(i) Recipient is liable for the payment; and
(ii) Department or managed care organization, if the recipient is enrolled with a managed care organization, is not covering the service.

2. If a recipient makes payment for a service in accordance with subparagraph, the
   a. Level I or Level II psychiatric residential treatment facility shall not bill the department or managed care organization, if applicable, for the services; and
   b. Department or managed care organization, if applicable, shall not:
      (i) Be liable for any part of the payment associated with the service; and
      (ii) Make any payment to the Level I or Level II psychiatric residential treatment facility regarding the service.
   c. Except as established in paragraph (b) of this subsection or except for a cost sharing obligation owned by a recipient, a provider shall not bill a recipient for any part of a service provided to the recipient.

(9) (a) A Level I or Level II psychiatric residential treatment facility attest by the Level I or Level II psychiatric residential treatment facility's staff's or representative's signature that any claim associated with a service is valid and submitted to good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:
1. Department or its designee;
2. Cabinet for Health and Family Services, Office of Inspector General, or its designee;
3. Kentucky Office of Attorney General or its designee;
4. Kentucky Office of the Auditor for Public Accounts or its designee;
5. United States General Accounting Office or its designee; or
5. For an enrollee, managed care organization in which the enrollee is enrolled.

(c) 1. If a Level I or Level II psychiatric treatment facility receives a request from the:
   a. Department to provide a claim, related information, related documentation, or record for auditing purposes, the Level I or Level II psychiatric residential treatment facility shall provide the requested information to the department within the timeframe requested by the department; or
   b. Managed care organization in which an enrollee is enrolled to provide a claim, related information, related documentation, or record for auditing purposes, the Level I or Level II psychiatric residential treatment facility shall provide the requested information to the managed care organization within the timeframe requested by the managed care organization.

2. a. The timeframe requested by the department or managed care organization for a Level I or Level II psychiatric residential treatment facility to provide requested information shall be:
   (i) A reasonable amount of time given the nature of the request and the circumstances surrounding the request; and
   (ii) A minimum of one (1) business day.
   b. A Level I or Level II psychiatric residential treatment facility may request a longer timeframe to provide information to the department or a managed care organization if the Level I or Level II psychiatric residential treatment facility justifies the need for a longer timeframe.

(d) 1. All services provided shall be subject to review for recipient or provider abuse.
2. Willful abuse by a Level I or Level II psychiatric residential treatment facility shall result in the suspension or termination of the Level I or Level II psychiatric residential facility from Medicaid Program participation in accordance with 907 KAR 1:671.

Section 3. Covered Admissions.

(1) A covered admission for a Level I PRTF:
(a) Shall be prior authorized by a review agency; and
(b) 1. Shall be limited to those for a child age six (6) through twenty (20) years of age who meets Medicaid payment status criteria; or
2. May continue based on medical necessity, for a recipient who is receiving active treatment in a Level I PRTF on the recipient's twenty-first (21st) birthday if the recipient has not reached his or her twenty-second (22nd) birthday.

(2) A covered admission for a Level II PRFT shall be:
(a) Prior authorized;
(b) Limited to those for a child:
1. a. Age four (4) through twenty-one (21) years who meets Medicaid payment status criteria; and
b. Whose coverage may continue, based on medical necessity, if the recipient is receiving active treatment in a Level II PRTF on the recipient's twenty-first (21st) birthday and the recipient has not reached his or her twenty-second (22nd) birthday;
2. With a severe emotional disability in addition to severe and persistent aggressive behaviors, an intellectual disability, sexually acting out behaviors, or a developmental disability; and
3. a. Who does not meet the medical necessity criteria for an acute care hospital, private psychiatric hospital, or state mental hospital; and
b. Whose treatment needs cannot be met in an ambulatory care setting, Level I PRTF, or in any other less restrictive environment; and
(c) Reimbursed pursuant to 907 KAR 9:010.

Section 4. PRTF Covered Services.

(1) (a) There shall be a treatment plan developed for each recipient.
(b) A treatment plan shall specify:
1. The amount and frequency of services needed; and
2. The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.

(2) To be covered by the department:
(a) The following services shall be available to a recipient covered under Section 3 of this administrative regulation and shall meet the requirements established in paragraph (b) of this subsection:
1. Diagnostic and assessment services;
2. Treatment plan development, review, or revision;
3. Psychiatric services;

4. Nursing services which shall be provided in compliance with 902 KAR 20:320;
5. Medication which shall be provided in compliance with 907 KAR 1:019;
6. Evidence-based treatment interventions;
7. Individual therapy which shall comply with 902 KAR 20:320;
8. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
9. Group therapy which shall comply with 902 KAR 20:320;
10. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
11. Substance abuse education;
12. Activities that:
    a. Support the development of an age-appropriate daily living skill including positive behavior management or support; or
    b. Support and encourage the parent's ability to re-integrate the child into the home;
13. Crisis intervention which shall comply with:
    a. 42 C.F.R. 483.350 through 376; and
    b. 902 KAR 20:320;
14. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
15. Educational activities; or
16. Non-medical transportation services as needed to accomplish objectives;

(b) A Level I PRTF service listed in paragraph (a) of this subsection shall be:
1. Provided under the direction of a physician;
2. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
3. Medically necessary; and
4. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) A Level I PRTF service listed in subparagraph (a)7, 8, 9, 11, or 13 shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or

(d) A Level II PRTF service listed in paragraph (a) of this subsection shall be:
1. Provided under the direction of a physician;
2. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
3. Provided at least once a week:
    a. Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
    b. Except for diagnostic and assessment services which shall have no weekly minimum requirement;
4. Medically necessary; and
5. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

(3) A Level II PRTF service listed in subparagraph (a)7, 8, 9, 11, or 13 shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

Section 5. Determining Patient Status.

(1) The department shall review and evaluate the health status and care needs of a recipient in need of Level I or II PRTF care using the criteria identified in 907 KAR 3:130 to determine if a service or benefit is clinically appropriate.

(2) The care needs of a recipient shall meet the patient status criteria for:

(a) Level I PRTF care if the recipient requires:

1. Long term inpatient psychiatric care or crisis stabilization more suitably provided in a PRTF than in a psychiatric hospital; and
2. Level I PRTF services on a continuous basis as a result of a severe mental or psychiatric illness, including a severe emotional disturbance; or

(b) Level II PRTF care if the recipient:

1. Is a child with a severe emotional disability;
2. Requires long term inpatient psychiatric care or crisis stabilization more suitably provided in a PRTF than a psychiatric hospital;
3. Requires Level II PRTF services on a continuous basis as a result of a severe emotional disability in addition to a severe and persistent aggressive behavior, an intellectual disability, a sexually acting out behavior, or a developmental disability; and
4. Does not meet the medical necessity criteria for an acute care hospital or a psychiatric hospital and has treatment needs which cannot be met in an ambulatory care setting, Level I PRTF, or other less restrictive environment.

Section 6. Durational Limit, Re-evaluation, and Continued Stay

(1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.

(2) (a) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria established in Section 5(2) of this administrative regulation.

(b) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.

(c) The review referenced in paragraph (b) of this subsection shall include:

1. Dated signatures of:
   a. Appropriate staff; and
   b. If present for the treatment plan meeting, a parent, guardian, legal custodian, or conservator;
2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
3. A statement of justification for the level of services needed including:
   a. Suitability for treatment in a less-restrictive environment; and
   b. Continued services.

(d) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.

(e) The re-evaluation referenced in paragraph (a) of this subsection shall be performed by a review agency.

(3) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:
   (a) Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
   (b) An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
   (c) A statement of justification for the level of services needed including:
      1. Suitability for treatment in a less-restrictive environment; and
      2. Continued services.

(4) (a) For a recipient aged four (4) to five (5) years, a Level II PRTF shall complete a review of the recipient's treatment plan of care at least once every fourteen (14) days after the initial review referenced in subsection (3) of this section.
   (b) The review referenced in paragraph (a) of this subsection shall include:
      1. Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
      2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
      3. A statement of justification for the level of services needed including:
         a. Suitability for treatment in a less-restrictive environment; and
         b. Continued services.

(5) (a) For a recipient aged six (6) to twenty-two (22) years, a Level II PRTF shall complete a review of the recipient's treatment plan of care at least once every thirty (30) days after the initial review referenced in subsection (3) of this section.
   (b) The review referenced in paragraph (a) of this subsection shall include:
      1. Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
      2. An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
      3. A statement of justification for the level of services needed including:
         a. Suitability for treatment in a less-restrictive environment; and
         b. Continued services.

Section 7. Exclusions and Limitations in Coverage.

(1) The following shall not be covered as Level I or II PRTF services under this administrative regulation:
   (a) Outpatient services, which shall be covered in accordance with 907 KAR 9:015;
   (b) Pharmacy services, which shall be covered in accordance with 907 KAR 1:019;
   (c) Durable medical equipment, which shall be covered in accordance with 907 KAR 1:479;
   (d) Hospital emergency room services, which shall be covered in accordance with 907 KAR 10:014;
   (e) Acute care hospital inpatient services, which shall be covered in accordance with 907 KAR 10:012;
   (f) Laboratory and radiology services, which shall be covered in accordance with 907 KAR 10:014 or 907 KAR 1:028;

(g) Dental services, which shall be covered in accordance with 907 KAR 1:026;
(h) Hearing and vision services, which shall be covered in accordance with 907 KAR 1:038; or
(i) Ambulance services, which shall be covered in accordance with 907 KAR 1:060.

(2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

(3) The department shall not reimburse for Level I or II PRTF services for a recipient if appropriate alternative services are available for the recipient in the community.

(4) The following shall not qualify as reimbursable in a PRTF setting:
(a) An admission that is not medically necessary; or
(b) Services for an individual:
1. With a major medical problem or minor symptoms;
2. Who might only require a psychiatric consultation rather than an admission to a PRTF; or
3. Who might need only adequate living accommodations, economic aid, or social support services.

Section 8. Reserved Bed and Therapeutic Pass Days.

(1) (a) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
1. Is in Medicaid payment status in a Level I or II PRTF;
2. Has been in the Level I or II PRTF overnight for at least one (1) night;
3. Is reasonably expected to return requiring Level I or II PRTF care; and
4. a. Has not exceeded the bed reserve day limit established in paragraph (b) of this subsection; or
b. Received an exception to the limit in accordance with paragraph (c) of this subsection.

(b) The annual bed reserve day limit per recipient shall be five (5) days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.

(c) The department shall allow a recipient to exceed the limit established in paragraph (b) of this subsection, if the department determines that an additional bed reserve day is in the best interest of the recipient.

(2) (a) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
1. Is in Medicaid payment status in a Level I or II PRTF;
2. Has been in the Level I or II PRTF overnight for at least one (1) night;
3. Is reasonably expected to return requiring Level I or II PRTF care; and
4. a. Has not exceeded the therapeutic pass day limit established in paragraph (b) of this subsection; or
b. Received an exception to the limit in accordance with paragraph (c) of this subsection.

(b) The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.

(c) The department shall allow a recipient to exceed the limit established in paragraph (b) of this subsection, if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

(3) The bed reserve day and therapeutic pass day count for each recipient shall be zero on January 1 of each calendar year.

(4) An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits established in this section shall be performed by a review agency.

(5) (a) An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.

(b) A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.

(c) A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

1. Stated in the recipient's treatment plan; and
2. Approved by the recipient's treatment team.

(6) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.

(b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.

(c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

Section 9. Outpatient Services Requirements Established in 907 KAR 9:015.

The department's coverage provisions and requirements regarding outpatient behavioral health services provided by a Level I or II PRTF shall be as established in 907 KAR 9:015.

Section 10. Third Party Liability.

A Level I or Level II PRTF shall comply with KRS 205.622.

Section 11. Use of Electronic Signatures.

(1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A Level I PRTF or Level II PRTF that chooses to use electronic signatures shall:

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

1. Be adhered to be each of the Level I PRTF's or Level II PRTF's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:
1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:
1. A copy of the Level I PRTF's or Level II PRTF's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 12. Auditing Authority.

The department or the managed care organization in which an enrollee is enrolled shall have the authority to audit any:

(1) Claim;
(2) Medical record; or
(3) Documentation associated with any claim or medical record.

Section 13. Federal Financial Participation.

(1) The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(a) Receipt of federal financial participation for the coverage; and
(b) Centers for Medicare and Medicaid Services; approval of the coverage.
(2) The coverage of services provided by a licensed clinical alcohol and drug counselor or licensed clinical alcohol and drug counselor associated shall be contingent and effective upon approval by the Centers for Medicare and Medicaid Services.

Section 14. Appeal Rights.

(1) (a) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.
(b) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.
(2) An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.
(3) An appeal of a negative action regarding Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 15. Incorporation by Reference.

(1) The following material is incorporated by reference.
(a) "MAP-569, Certification of Need by Independent Team Psychiatric Preadmission Review of Elective Admissions for Kentucky Medicaid Recipients Under Age Twenty-One (21)", revised 5/90; and
(b) "MAP-570, Medicaid Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-one (21)", revised 5/90.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (18 Ky.R. 600; eff. 10-6-1991; Am. 19 Ky.R. 2340; eff. 6-16-1993; 22 Ky.R. 1906; eff. 6-6-1996; 27 Ky.R. 2910; 3267; eff. 6-8-2001; TAm.; eff. 5-3-2011; Recodified from 907 KAR 1:505; eff. 3-20-2012; TAm eff. 3-20-2012; 39 Ky.R. 629; 1218; 1413; eff. 3-8-2013; 41 KyR. 2417; 42 Ky.R. 386; 720; **eff. 11-16-2015**.)

Department for Medicaid Services - KRS 205.632. Pilot Project to create coverage provisions and reimbursement criteria for telemonitoring services based on evidence-based best practices provided by a qualified medical provider or community action agency.
www.lrc.ky.gov/Statutes/statute.aspx?id=45357

(1) As used in this section:
  (a) "Department" means the Department for Medicaid Services;
  (b) "Evidence-based best practices" means the integration of the best available research with clinical expertise in the context of patient characteristics and patient and family caregiver preferences;
  (c) "Qualified medical provider" means a credentialed and enrolled Medicaid-participating healthcare provider, hospital, rural health center, or licensed home health agency as defined in KRS 216.935; and
  (d) "Telemonitoring services" means services that require scheduled remote monitoring of data related to a patient's health where the monitoring is conducted at the patient's place of residence or other site determined by the department.
(2) Not later than July 1, 2017, the department shall establish a pilot project in which it creates coverage provisions and reimbursement criteria for telemonitoring services based on evidence-based best practices provided by a qualified medical provider or a community action agency as defined in KRS 273.410.
(3) In order to effectuate the pilot project, the department may:
  (a) Submit a state plan amendment, waiver, or waiver amendment for approval to the Centers for Medicare and Medicaid Services in order to provide coverage for medically necessary telemonitoring services performed for a Medicaid beneficiary;
  (b) Request funding from the General Assembly to support telemonitoring services rendered by a qualified medical provider or a community action agency under this section;
  (c) Ensure that clinical information gathered by a qualified medical provider or a community action agency while providing telemonitoring services is shared with the patient's treating health care professionals; and
  (d) Promulgate administrative regulations in accordance with KRS Chapter 13A for the implementation and administration of this section.

Effective: July 15, 2016
History: Created 2016 Ky. Acts ch. 126, sec. 1, effective July 15, 2016.

KENTUCKY BOARD OF NURSING

KRS 314.155 Duty of treating nurse utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=30935

(1) A treating nurse who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of nursing services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 13, effective July 14, 2000.

Kentucky Board of Nursing - 201 KAR 20:520. Telehealth.

www.lrc.ky.gov/kar/201/020/520.htm

RELATES TO: KRS 314.155
STATUTORY AUTHORITY: KRS 314.131, 314.155
NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the board to promulgate administrative regulations necessary to carry out the provisions of KRS Chapter 314. KRS 314.155(2) requires the board to promulgate administrative regulations regarding telehealth, including preventing abuse and fraud through the use of telehealth services, preventing fee-splitting through the use of telehealth services, and utilizing telehealth in the provision of nursing services and in the provision of continuing education. This administrative regulation establishes the requirements governing the use of telehealth.

Section 1. Definitions.
(1) "Board" is defined by KRS 314.011(1).

(2) "Nurse" means a licensed practical nurse as defined by KRS 314.011(9), a registered nurse as defined by KRS 314.011(5), or an advanced practice registered nurse as defined by KRS 314.011(7).
(3) "Telehealth" is defined by KRS 314.155(3).

Section 2. Jurisdictional Considerations.
A nurse providing nursing services via telehealth to a person physically located in Kentucky shall be licensed by the board or hold a privilege to practice pursuant to KRS 314.470.

Section 3. Representation of Services and Code of Conduct.
A nurse using telehealth to deliver services shall not:
(1) Engage in false, misleading, or deceptive advertising; or
(2) Split fees.

Section 4. Initial Communication Requirements.
A nurse using telehealth to deliver nursing services shall, upon initial contact with the patient:
(1) Make attempts to verify the identity of the patient;
(2) Obtain alternative means of contacting the patient other than electronically such as by use of a telephone number or mailing address;
(3) Provide to the patient alternative means of contacting the nurse other than electronically such as by use of a telephone number or mailing address; and
(4) Provide contact methods of alternative communication the nurse shall use for emergency purposes such as an emergency on call telephone number.

Section 5. Limits on Practice, Informed Consent, Maintenance, and Retention of Records.
A nurse using telehealth to deliver nursing services shall:
(1) Be responsible for determining and documenting that telehealth is appropriate for the patient;
(2) Document which services were provided by telehealth;
(3) Use secure communications with each patient, including encrypted text messages, via e-mail or secure Web sites, and not use personal identifying information in non-secure communications;
(4) Ensure that confidential communications obtained and stored electronically cannot be recovered and accessed by unauthorized persons when the nurse disposes of electronic equipment and data; and
(5) Inform the patient and document acknowledgement of the risk and limitations of:
    (a) The use of telehealth in the provision of nursing;
    (b) The potential breach of confidentiality, or inadvertent access, of protected health information using telehealth in the provision of nursing;
    (c) The potential disruption of electronic communication in the use of telehealth;
    (d) When and how the nurse will respond to routine electronic messages;
    (e) The circumstances in which the nurse will use alternative communications for emergency purposes;
    (f) Others who may have access to patient communications with the nurse;
    (g) How communications shall be directed to a specific nurse;

(h) How the nurse stores electronic communications from the patient; and
(i) Whether the nurse or patient may elect to discontinue the provision of services through telehealth.

Section 6. Utilization of Telehealth in Provision of Continuing Education.
Providers approved pursuant to 201 KAR 20:220 may utilize telehealth in the provision of continuing education courses. (42 Ky.R. 2684; 43 Ky.R. 19; **eff. 7-20-2016.)**

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY

KRS 319A.300. Duty of treating occupational therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31275

(1) A treating occupational therapist who provides or facilitates the use of telehealth shall ensure:
  (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
  (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.
(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
  (a) Prevent abuse and fraud through the use of telehealth services;
  (b) Prevent fee-splitting through the use of telehealth services; and
  (c) Utilize telehealth in the provision of occupational therapy services and in the provision of continuing education.
(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 17, effective July 14, 2000.

Kentucky Board of Licensure for Occupational Therapy - 201 KAR 28:230. Telehealth occupational therapy services. (FILED 11-15-2016) www.lrc.ky.gov/kar/201/028/230reg.htm

RELATES TO: KRS 319A.080, 319A.300
STATUTORY AUTHORITY: KRS 319A.300

NECESSITY, FUNCTION, AND CONFORMITY: KRS 319A.300(2) requires the board to promulgate an administrative regulation to implement telehealth in occupational therapy, including to establish procedures to prevent abuse and fraud through the use of telehealth, prevent fee-splitting through the use of telehealth, and utilize telehealth in the provision of occupational therapy services and in the provision of continuing education. Additionally, KRS 319A.300(1) requires an occupational therapist utilizing telehealth to ensure a patient's informed consent and to maintain confidentiality. This administrative regulation establishes the requirements for telehealth for occupational therapy services.

Section 1. Definitions.

(1) "Telehealth" is defined by KRS 319A.300(3).

(2) "Telehealth occupational therapy" means the practice of occupational therapy as defined by KRS 319A.010(2), between the occupational therapist and the patient that is provided using:
   (a) An electronic communication technology; or
   (b) Two (2) way, interactive, simultaneous audio and video.

Section 2. Client Requirements.

A credential holder using telehealth to deliver occupational therapy services shall, upon initial contact with the client:

(1) Make reasonable attempts to verify the identity of the client;

(2) Obtain alternative means of contacting the client other than electronically;

(3) Provide to the client alternative means of contacting the credential holder other than electronically;

(4) Document if the client has the necessary knowledge and skills to benefit from the type of telehealth provided by the credential holder;

(5) Use secure communications with clients, including encrypted text messages via e-mail or secure Web sites, and not use personal identifying information in non-secure communications; and

(6) Inform the client in writing about:
   (a) The limitations of using technology in the provision of telehealth occupational therapy services;
   (b) Potential risks to confidentiality of information due to technology in the provision of telehealth occupational therapy services;
   (c) Potential risks of disruption in the use of telehealth occupational therapy services;
   (d) When and how the credential holder will respond to routine electronic messages;
   (e) In what circumstances the credential holder will use alternative communications for emergency purposes;
   (f) Who else may have access to client communications with the credential holder;
   (g) How communications can be directed to a specific credential holder; and
   (h) How the credential holder stores electronic communications from the client.

Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records.

A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall:

(1) Limit the practice of telehealth occupational therapy to the area of competence in which proficiency has been gained through education, training, and experience;
(2) Maintain current competency in the practice of telehealth occupational therapy through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge;
(3) Document the client's presenting problem, purpose, or diagnosis;
(4) Follow the record-keeping requirements of 201 KAR 28:140; and
(5) Ensure that confidential communications obtained and stored electronically cannot be recovered and accessed by unauthorized persons when the credential holder disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law.
A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall comply with:
(1) State law where the credential holder is credentialed and be licensed to practice occupational therapy where the client is domiciled or adhere to standards set forth in 201 KAR 28:030; and
(2) Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with disabilities.

Section 5. Representation of Services and Code of Conduct.
(1) A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall:
  (a) Not by or on behalf of the credential holder engage in false, misleading, or deceptive advertising of telehealth occupational therapy;
  (b) Comply with 201 KAR 28:140; and
  (c) Not allow fee-splitting through the use of telehealth occupational therapy services.
(2) Occupational therapy continuing competence educational processes established in 201 KAR 28:200, Section 3(1), (2), (3), (5), (8), and (11), may occur through telehealth services.

KEVIN PRIDDY, COTA/L, Board Chair

APPROVED BY AGENCY: October 13, 2016

FILED WITH LRC: November 15, 2016 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on December 22, 2016 at 9:00 a.m. (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on December 31, 2016. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Kelly Walls, Board Administrator, Kentucky Board of Licensure for Occupational Therapy, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296, fax 502-564-4818, email kelly.walls@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT
Contact Persons: Kelly Walls, Kevin Priddy (phone 270-202-1701; kevinkblot@gmail.com)

(1) Provide a brief summary of:
   (a) What this administrative regulation does: This administrative regulation sets forth the requirements for licensees who use telehealth in delivering health care to patients.
   (b) The necessity of this administrative regulation: This administrative regulation is necessary to implement the requirements under KRS 319A.300(2).
   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 319A.300(2).
   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation implements the requirements of KRS 319A.300.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
   (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
   (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
   (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
   (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation impacts all licensees regulated by KRS Chapter 319A.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
   (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each licensee will have to adhere to the requirements of KRS 319A.300 that prohibits fee splitting and each licensee shall have to meet the requirements for clients, obtain competency in the use of telehealth, assure confidentiality, follow record keeping requirements of 201 KAR 28:140, and follow federal law requiring access for persons with disabilities.
   (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The costs will vary and the licensee is not required to offer telehealth services.
   (c) As a result of compliance, what benefits will accrue to the entities identified in question. All licensees will have the option of offering telehealth services to their patients.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
   (a) Initially: No additional costs are necessary to implement the changes made by this regulation.
   (b) On a continuing basis: No additional costs are necessary to implement the changes made by this regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The fees for persons licensed under KRS 319A.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish fees

(9) TIERING: Is tiering applied? No tiering is applied because all licensees will be held to the same standards.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Licensure for Occupational Therapy.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 319A.300 (2).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.
   (a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.
   (c) How much will it cost to administer this program for the first year? None.
   (d) How much will it cost to administer this program for subsequent years? None.

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

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

KENTUCKY BOARD OF OPTOMETRIC EXAMINERS

KRS 320.390. Duty of treating optometrist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth." www.lrc.ky.gov/Statutes/statute.aspx?id=31352

(1) A treating optometrist who provides or facilitates the use of telehealth shall ensure:
  (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
  (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
  (a) Prevent abuse and fraud through the use of telehealth services;
  (b) Prevent fee-splitting through the use of telehealth services; and
  (c) Utilize telehealth in the provision of optometric services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 18, effective July 14, 2000.

Kentucky Board of Optometric Examiners - 201 KAR 5:055. Telehealth.

www.lrc.ky.gov/kar/201/005/055.htm

RELATES TO: KRS 320.390
STATUTORY AUTHORITY: KRS 320.390(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 320.390(2) requires the Board of Optometric Examiners to promulgate administrative regulations to prevent abuse and fraud through the use of telehealth services, prevent fee-splitting through the use of telehealth services, and utilize telehealth in the provision of optometric services and in the provision of continuing education. This administrative regulation establishes these requirements.

Section 1. Definitions.

(1) “Contact lens prescription” is defined by KRS 367.680(3).

(2) “Eye examination” is defined by 201 KAR 5:040, Section 7(1)(a).

(3) “Face to face” means in person and not via telehealth.

(4) "Licensed health care professional" means an optometrist licensed pursuant to KRS Chapter 320, or a physician or osteopath licensed under KRS 311.550(12).
(5) "Optometrist" means an individual licensed by the Kentucky Board of Optometric Examiners as defined by KRS 320.210(2).
(6) "Patient" means the person receiving services or items from an optometrist or a physician.
(7) "Physician" means an individual licensed by the Kentucky Board of Medical Licensure as defined by KRS 311.550(12).
(8) "Prescription" means an order for a pharmaceutical agent, or any other therapy within the scope of practice of an optometrist or a physician.
(9) "Prescription for eyewear" means a written prescription for visual aid glasses or contact lenses after a complete eye examination is performed by an optometrist or physician.
(10) "Telehealth" is defined by KRS 320.290(3).
(11) "Telehealth provider" means an optometrist or physician who performs a telehealth consultation.
(12) "Telepractice" means the practice of optometry as defined in KRS Chapter 320 that is provided by using communication technology that is two (2) way, interactive, simultaneous audio and video.
(13) "Visual aid glasses" is defined by KRS 320.210(4).

Section 2. Patient Identity, Communication and Informed Consent Requirements.

(1) An optometrist-patient relationship shall not commence via telehealth.
(2) An initial, in-person meeting for the optometrist and patient who will prospectively utilize telehealth shall occur in order to evaluate whether the potential or current patient is a candidate to receive services via telehealth.
(3) An optometrist who uses telehealth to deliver vision or eye care services shall at the initial, face-to-face meeting with the patient:
    (a) Verify the identity of the patient;
    (b) Establish a medical history and permanent record for the patient;
    (c) Obtain alternative means of contacting the patient other than electronically such as by the use of a telephone number or mailing address;
    (d) Provide to the patient alternative means of contacting the optometrist other than electronically such as by the use of a telephone number of mailing address;
    (e) Provide contact methods of alternative communication the optometrist shall use for emergency purposes such as an emergency on call telephone number;
    (f) Document if the patient has the necessary knowledge and skills to benefit from the type of telepractice provided by the optometrist; and
    (g) Inform the patient in writing and document acknowledgement of the risk and limitations of:
        1. The use of technology in the use of telehealth;
        2. The potential breach of confidentiality of information or inadvertent access of protected health information due to technology in telepractice;
        3. The potential disruption of technology in the use of telepractice;
        4. When and how the optometrist will respond to routine electronic messages;
        5. The circumstances in which the optometrist will use alternative communications for emergency purposes;
        6. Who else may have access to patient communications with the optometrist;

7. How communications shall be directed to a specific optometrist;
8. How the optometrist stores electronic communications from the patient; and
9. Whether the optometrist may elect to discontinue the provision of services through telehealth.

Section 3. Jurisdictional Considerations.
A person providing eye and vision services via telehealth:
(1) Shall be licensed by the Kentucky Board of Optometric Examiners or the Kentucky Board of Medial Licensure if, at the time services are provided, the services are provided:
  (a) To a person physically located in Kentucky; or
  (b) By a person who is physically located in Kentucky; and
(2) May be subject to licensure requirements in other states where the services are received by the client.

Section 4. Representation of Services and Code of Conduct.
(1) A telehealth provider shall not engage in false, misleading, or deceptive advertising. A person shall not advertise an eye examination unless the requirements of 201 KAR 5:040, Section 7(1)(a) are met. A person shall not purport to write a prescription for visual aid glasses or contact lenses solely by using an autorefractor or other automated testing device.
(2) Treatment and consultation recommendations made in an online setting, including a prescription or a prescription for visual aid glasses via electronic means, shall be held to the same standards of appropriate practice as those in traditional practice, face-to-face settings. Treatment, including issuing a prescription for visual aid glasses based solely on an online autorefraction, shall not consititute an acceptable practice or standard of care.
(3) Prescription for controlled substances shall not be made via telehealth.
(4) A telehealth provider shall:
  (a) Not split fees in accordance with KRS 320.300(3);
  (b) Shall maintain a medical record of a service or item provided to a patient via telepractice;
  (c) Document the patient's presenting problem, purpose, or diagnosis and include which services were provided by telepractice;
  (d) Use secure communications with each patient including encrypted text messages, via email or secure Web site and not use personal identifying information in non-secure communications; and
  (e) Dispense visual aids only in accordance with KRS 320.300(1).

Section 5. Utilization of Telehealth in Provision of Continuing Education.
Educational presentations are permitted via telehealth in accordance with 201 KAR 5:030.

Section 6. This administrative regulation shall not be construed as giving jurisdiction over physicians licensed under KRS Chapter 311 to the Kentucky Board of Optometric Examiners. (41 Ky.R. 672, 1040; 1308; **eff. 11-19-2014**.)

KENTUCKY BOARD OF PHARMACY

KRS 315.310. Duty of treating pharmacist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31038

(1) A treating pharmacist who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of pharmacy services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 15, effective July 14, 2000.

KENTUCKY BOARD OF PHYSICAL THERAPY

KRS 327.200. Duty of treating physical therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31724

(1) A treating physical therapist who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
  (a) Prevent abuse and fraud through the use of telehealth services;
  (b) Prevent fee-splitting through the use of telehealth services; and
  (c) Utilize telehealth in the provision of physical therapy and in the provision of continuing education.
(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 19, effective July 14, 2000.

Kentucky Board of Physical Therapy - 201 KAR 22:160. Telehealth and telephysical therapy.

www.lrc.ky.gov/kar/201/022/160.htm

RELATES TO: KRS 327.200
STATUTORY AUTHORITY: KRS 327.040(11), (12), 327.200(1), (2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 327.040(11) authorizes the board to promulgate and enforce reasonable administrative regulations for the effectuation of the purposes of KRS Chapter 327. KRS 327.040(12) requires the board to promulgate by administrative regulation standards of practice. KRS 327.200(1) requires a treating physical therapist utilizing telehealth to ensure a patient's informed consent and to maintain confidentiality. KRS 327.200(2) requires the board to promulgate administrative regulations necessary to implement telehealth. This administrative regulation establishes procedures necessary to prevent abuse and fraud through the use of telehealth, prevent fee-splitting through the use of telehealth, and utilize telehealth in the provision of physical therapy services and in the provision of continuing education.

Section 1. Patient Identity, Communication, and Informed Consent Requirements.
A credential holder using telehealth to deliver physical therapy services or who practices telephysical therapy shall, upon an initial contact with the patient:
(1) Verify the identity of the patient;
(2) Obtain alternative means of contacting the patient;
(3) Provide to the patient alternative means of contacting the credential holder;
(4) Provide contact methods of alternative communication the credential holder shall use for emergency purposes;
(5) Not use personal identifying information in non-secure communications; and
(6) Inform the patient and document acknowledgement of the risk and limitations of:
  (a) The use of electronic communications in the provision of physical therapy;
  (b) The potential breach of confidentiality, or inadvertent access, of protected health information using electronic communication in the provision of physical therapy; and
  (c) The potential disruption of electronic communication in the use of telephysical therapy.

Section 2. Competence, Limits on Practice, Maintenance, and Retention of Records.
A credential holder using electronic communication to deliver physical therapy services or who practices telephysical therapy shall:
(1) Be responsible for determining and documenting that telehealth is appropriate in the provision of physical therapy;
(2) Limit the practice of telephysical therapy to the area of competence in which proficiency has been gained through education, training, and experience;
(3) Document which physical therapy services were provided by telephysical therapy;
(4) Follow the record-keeping requirements of 201 KAR 22:053, Section 5; and
(5) Ensure that confidential communications obtained and stored electronically shall not be recovered and accessed by unauthorized persons when the credential holder disposes of electronic equipment and data.

Section 3. Compliance with State Law. A credential holder practicing telephysical therapy shall be:
(1) Licensed to practice physical therapy where the patient is physically present or domiciled; or
(2) Otherwise authorized by law to practice physical therapy in another jurisdiction where the patient is physically present or domiciled. (40 Ky.R. 2227; 41 Ky.R. 32; **eff. 8-1-2014.)**

PHYSICIANS, OSTEOPATHS, PODIATRISTS, AND RELATED MEDICAL PRACTITIONERS

311.550. Definitions for KRS 311.530 to 311.620 and KRS 311.990(4) to (6).
www.lrc.ky.gov/Statutes/statute.aspx?id=30519

As used in KRS 311.530 to 311.620 and KRS 311.990(4) to (6):
(1) "Board" means the State Board of Medical Licensure;
(2) "President" means the president of the State Board of Medical Licensure;
(3) "Secretary" means the secretary of the State Board of Medical Licensure;
(4 "Executive director" means the executive director of the State Board of Medical Licensure or any assistant executive directors appointed by the board;
(5) "General counsel" means the general counsel of the State Board of Medical Licensure or any assistant general counsel appointed by the board;
(6) "Regular license" means a license to practice medicine or osteopathy at any place in this state;
(7) "Limited license" means a license to practice medicine or osteopathy in a specific institution or locale to the extent indicated in the license;
(8) "Temporary permit" means a permit issued to a person who has applied for a regular license, and who appears from verifiable information in the application to the executive director to be qualified and eligible therefor;
(9) "Emergency permit" means a permit issued to a physician currently licensed in another state, authorizing the physician to practice in this state for the duration of a specific medical emergency, not to exceed thirty (30) days;

(10) Except as provided in subsection (11) of this section, the "practice of medicine or osteopathy" means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;

(11) The "practice of medicine or osteopathy" does not include the practice of Christian Science, the domestic administration of family remedies, the rendering of first aid or medical assistance in an emergency in the absence of a person licensed to practice medicine or osteopathy under the provisions of this chapter, the use of automatic external defibrillators in accordance with the provisions of KRS 311.665 to 311.669, the practice of podiatry as defined in KRS 311.380, the practice of a midlevel health care practitioner as defined in KRS 216.900, the practice of dentistry as defined in KRS 313.010, the practice of optometry as defined in KRS 320.210, the practice of chiropractic as defined in subsection (2) of KRS 312.015, the practice as a nurse as defined in KRS 314.011, the practice of physical therapy as defined in KRS 327.010, the performance of duties for which they have been trained by paramedics licensed under KRS Chapter 311A, first responders, or emergency medical technicians certified under Chapter 311A, the practice of pharmacy by persons licensed and registered under KRS 315.050, the sale of drugs, nostrums, patented or proprietary medicines, trusses, supports, spectacles, eyeglasses, lenses, instruments, apparatus, or mechanisms that are intended, advertised, or represented as being for the treatment, correction, cure, or relief of any human ailment, disease, injury, infirmity, or condition, in regular mercantile establishments, or the practice of midwifery by women. KRS 311.530 to 311.620 shall not be construed as repealing the authority conferred on the Cabinet for Health and Family Services by KRS Chapter 211 to provide for the instruction, examination, licensing, and registration of all midwives through county health officers;

(12) "Physician" means a doctor of medicine or a doctor of osteopathy;

(13) "Grievance" means any allegation in whatever form alleging misconduct by a physician;

(14) "Charge" means a specific allegation alleging a violation of a specified provision of this chapter;

(15) "Complaint" means a formal administrative pleading that sets forth charges against a physician and commences a formal disciplinary proceeding;

(16) As used in KRS 311.595(4), "crimes involving moral turpitude" shall mean those crimes which have dishonesty as a fundamental and necessary element, including but not limited to crimes involving theft, embezzlement, false swearing, perjury, fraud, or misrepresentation;

(17 "Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education;

(18) "Order" means a direction of the board or its panels made or entered in writing that determines some point or directs some step in the proceeding and is not included in the final order;

(19) "Agreed order" means a written document that includes but is not limited to stipulations of fact or stipulated conclusions of law that finally resolves a grievance, a complaint, or a show cause order issued informally without expectation of further formal proceedings in accordance with KRS 311.591(6);

(20) "Final order" means an order issued by the hearing panel that imposes one (1) or more disciplinary sanctions authorized by this chapter;

(21) "Letter of agreement" means a written document that informally resolves a grievance, a complaint, or a show cause order and is confidential in accordance with KRS 311.619;

(22) "Letter of concern" means an advisory letter to notify a physician that, although there is insufficient evidence to support disciplinary action, the board believes the physician should modify or eliminate certain practices and that the continuation of those practices may result in action against the physician's license;
(23) "Motion to revoke probation" means a pleading filed by the board alleging that the licensee has violated a term or condition of probation and that fixes a date and time for a revocation hearing;
(24) "Revocation hearing" means a hearing conducted in accordance with KRS Chapter 13B to determine whether the licensee has violated a term or condition of probation;
(25) "Chronic or persistent alcoholic" means an individual who is suffering from a medically diagnosable disease characterized by chronic, habitual, or periodic consumption of alcoholic beverages resulting in the interference with the individual's social or economic functions in the community or the loss of powers of self-control regarding the use of alcoholic beverages;
(26) "Addicted to a controlled substance" means an individual who is suffering from a medically diagnosable disease characterized by chronic, habitual, or periodic use of any narcotic drug or controlled substance resulting in the interference with the individual's social or economic functions in the community or the loss of powers of self-control regarding the use of any narcotic drug or controlled substance;
(27) "Provisional permit" means a temporary permit issued to a licensee engaged in the active practice of medicine within this Commonwealth who has admitted to violating any provision of KRS 311.595 that permits the licensee to continue the practice of medicine until the board issues a final order on the registration or reregistration of the licensee;
(28) "Fellowship training license" means a license to practice medicine or osteopathy in a fellowship training program as specified by the license; and
(29) "Special faculty license" means a license to practice medicine that is limited to the extent that this practice is incidental to a necessary part of the practitioner's academic appointment at an accredited medical school program or osteopathic school program and any affiliated institution for which the medical school or osteopathic school has assumed direct responsibility.

Effective: July 12, 2006

History: Amended 2006 Ky. Acts ch. 175, sec. 1, effective July 12, 2006. -- Amended 2005 Ky. Acts ch. 99, sec. 585, effective June 20, 2005. -- Amended 2004 Ky. Acts ch. 35, sec. 1, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 130, sec. 4, effective July 15, 2002; and ch. 211, sec. 35, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 343, sec. 18, effective July 14, 2000; and ch. 376, sec. 8, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 228, sec. 1, effective July 15, 1998; and ch. 426, sec. 537, effective July 15, 1998. -- Amended 1990 Ky. Acts ch. 482, sec. 11, effective July 13, 1990. -- Amended 1986 Ky. Acts ch. 302, sec. 5, effective July 15, 1986. -- Amended 1984 Ky. Acts ch. 251, sec. 1, effective July 13, 1984. -- Amended 1980 Ky. Acts ch. 188, sec. 251, effective July 15, 1980. -- Amended 1978 Ky. Acts ch. 107, sec. 1, effective June 17, 1978. -- Amended 1974 Ky. Acts ch. 74, Art. VI, sec. 90(9); and ch. 331, sec. 1. -- Amended 1972 Ky. Acts ch. 218, sec. 5. -- Amended 1968 Ky. Acts ch. 152, sec. 146. -- Amended 1958 Ky. Acts ch. 126, sec. 29. -- Created 1952 Ky. Acts ch. 150, sec. 1.

Physicians, Osteopaths, Podiatrists & Related Medical Practitioners – KRS 311.560. Prohibition against practice of medicine or osteopathy without license -- Exceptions.
www.lrc.ky.gov/Statutes/statute.aspx?id=30521

(1) Except as provided in subsection (2) of this section, no person shall engage or attempt to engage in the practice of medicine or osteopathy within this state, or open, maintain, or occupy an office or place of business within this state for engaging in practice, or in any manner announce or express a readiness to engage in practice within this state, unless the person holds a valid and effective license or permit issued by the board as hereinafter provided.

(2) The provisions of subsection (1) of this section shall not apply to:

(a) Commissioned medical officers of the Armed Forces of the United States, or medical officers of the United States Public Health Service, the United States Veterans Administration, and other agencies of the government of the United States of America, while said persons are engaged in the performance, within this state, of their official duties under federal laws;

(b) 1. Persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a physician licensed pursuant to this chapter; or

2. Persons who, being current participants in a medical residency program outside of Kentucky and lawfully licensed to practice medicine or osteopathy in the states of their medical residency programs, who participate in a temporary residency rotation of no more than sixty (60) days at a hospital in this Commonwealth. All persons who participate in a temporary residency rotation under this paragraph shall register with the board at no cost, on forms provided by the board, and shall be subject to the jurisdiction of the board for so long as they participate in the residency rotation. Persons who wish to participate in a second or subsequent temporary residency rotation under this paragraph shall seek advance approval of the board;

(c) Graduates of medical or osteopathic schools approved by the board, while engaged in performing supervised internship or first-year postgraduate training approved by the board at hospitals in this state. All first-year postgraduate trainees shall register with the board at no cost, on forms provided by the board. No first-year postgraduate trainee shall violate the provisions of KRS 311.595 or KRS 311.597, and any first-year postgraduate trainee who is released or discharged from a training program for a reason that falls within KRS 311.595 or 311.597 shall be reported by the program director to the board. A residency physician who participates in a temporary residency rotation under paragraph (b) of this subsection shall not be required to obtain a license under KRS 311.530 to 311.620;

(d) Physicians employed by a sports entity visiting Kentucky for a specific sporting event when the physician holds an active medical or osteopathic license in another state and limits the practice of medicine in Kentucky to medical treatment of the members, coaches, and staff of the sports entity that employs the physician; or

(e) Persons who are nonresidents of Kentucky and licensed to practice medicine or osteopathy in their states of residence and are providing medical services as a charitable health-care provider in Kentucky through a nonprofit, all-volunteer sponsoring organization as provided for under KRS 216.940 to 216.945, after confirming to the board that their licenses are currently in good standing in their states of residence and having been issued a written waiver by the board to provide these services during the specific period stated in the written waiver.

Effective: June 25, 2009

History: Amended 2009 Ky. Acts ch. 5, sec. 2, effective June 25, 2009. -- Amended 2007 Ky. Acts ch. 96, sec. 10, effective June 26, 2007. -- Amended 2004 Ky. Acts ch. 35, sec. 3, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 130, sec. 5, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 291, sec. 1, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 228, sec. 2, effective July 15, 1998. -- Amended 1990 Ky. Acts ch. 495, sec. 12, effective January 1, 1991. -- Amended 1972 Ky. Acts ch. 218, sec. 7. -- Created 1952 Ky. Acts ch. 150, sec. 3, effective June 19, 1952.

Physicians, Osteopaths, Podiatrists & Related Medical Practitioners - KRS 311.5975 Duty of treating physician utilizing telehealth to insure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations.

www.lrc.ky.gov/Statutes/statute.aspx?id=30539

(1) A treating physician who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designed by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of medical services and in the provision of continuing medical education.

Effective: **July 14, 2000**

History: Created 2000 Ky.Acts Ch. 376, sec. 9, effective July 14, 2000.

Physicians, Osteopaths, Podiatrists & Related Medical Practitioners - KRS 311.724. Informed consent given in "individual, private setting."
www.lrc.ky.gov/Statutes/statute.aspx?id=44918

If a section of the Kentucky Revised Statutes uses the phrase "individual, private setting" to describe the conditions under which informed consent must be given to a medical procedure, then the informed consent offered in accordance with that section shall be considered valid only if a physician or a licensed nurse, physician assistant, or social worker to whom the responsibility has been delegated by the physician has a face-to-face meeting with the patient and both parties are physically located in the same room or are participating in real-time visual telehealth services initiated by the physician or by the patient.
Effective: July 15, 2016
History: Created 2016 Ky. Acts ch. 1, sec. 1, effective July 15, 2016.

KENTUCKY BOARD OF EXAMINERS OF PSYCHOLOGY

KRS 319.140. Duty of treating psychologist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=31252

(1) A treating psychologist or psychological associate who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of psychological services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 16, effective July 14, 2000.

Kentucky Board of Examiners of Psychology - 201 KAR 26:310. Telehealth and telepsychology.
www.lrc.ky.gov/kar/201/026/310.htm

RELATES TO: KRS 319.140, 29 U.S.C. 794(d)
STATUTORY AUTHORITY: KRS 319.032(2); KRS 319.140(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 319.140 requires a treating psychologist utilizing telehealth to ensure a patient's informed consent and to maintain confidentiality. This administrative regulation protects the health and safety of the citizens of Kentucky and establishes procedures for preventing abuse and fraud through the use of telehealth, prevents fee-splitting through the use of telehealth, and utilizes telehealth in the provision of psychological services and in the provision of continuing education.

Section 1. Definitions.

(1) "Client" is defined by 201 KAR 26:145, Section 2;
(2) "Telehealth" is defined by KRS 319.140(3);
(3) "Telepsychology" means "practice of psychology" as defined by KRS 319.010(7) between the psychologist and the patient:
    (a) Provided using an electronic communication technology; or
    (b) Two (2) way, interactive, simultaneous audio and video.

Section 2. Client Requirements.

A credential holder using telehealth to deliver psychological services or who practices telepsychology shall, upon initial contact with the client:

(1) Make reasonable attempts to verify the identity of the client;
(2) Obtain alternative means of contacting the client other than electronically;
(3) Provide to the client alternative means of contacting the credential holder other than electronically;
(4) Document if the client has the necessary knowledge and skills to benefit from the type of telepsychology provided by the credential holder;
(5) Use secure communications with clients, including encrypted text messages via e-mail or secure Web sites, and not use personal identifying information in non-secure communications;
(6) Inform the client in writing about:
    (a) The limitations of using technology in the provision of telepsychology;
    (b) Potential risks to confidentiality of information due to technology in the provision of telepsychology;
    (c) Potential risks of disruption in the use of telepsychology;
    (d) When and how the credential holder will respond to routine electronic messages;

(e) In what circumstances the credential holder will use alternative communications for emergency purposes;
(f) Who else may have access to client communications with the credential holder;
(g) How communications can be directed to a specific credential holder;
(h) How the credential holder stores electronic communications from the client; and
(i) The reporting of clients required by 201 KAR 26:145, Section 7.

Section 3. Competence. Limits on Practice, Maintenance, and Retention of Records.
A credential holder using telehealth to deliver psychological services or who practices telepsychology shall:

(1) Limit the practice of telepsychology to the area of competence in which proficiency has been gained through education, training, and experience;
(2) Maintain current competency in the practice of telepsychology through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge;
(3) Document the client's presenting problem, purpose, or diagnosis;
(4) Follow the record-keeping requirements of 201 KAR 26:145, Section 6; and
(5) Ensure that confidential communications obtained and stored electronically cannot be recovered and accessed by unauthorized persons when the credential holder disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law. A credential holder using telehealth to deliver psychological services or who practices telepsychology shall comply with:

(1) State law where the credential holder is credentialed and be licensed to practice psychology where the client is domiciled; and
(2) Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with disabilities;

Section 5. Representation of Services and Code of Conduct. A credential holder using telehealth to deliver psychological services or who practices telepsychology;

(1) Shall not by or on behalf of the credential holder engage in false, misleading, or deceptive advertising of telepsychology;
(2) Shall comply with 201 KAR 26:145. (37 Ky.R. 1597; Am. 1987; **eff. 3-4-2011**.)

CABINET FOR HEALTH AND FAMILY SERVICES

KRS 211.195. Authorization for Department for Public Health to develop programs allowing local health departments to participate in telehealth and receive reimbursement.
www.lrc.ky.gov/Statutes/statute.aspx?id=8363

The Department for Public Health may develop programs for local health departments to participate in telehealth and to seek reimbursement for services as provided for other health care providers under KRS Chapter 205 or KRS Chapter 304, Subtitle 17A.
Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 5, effective July 14, 2000.

Cabinet for Health and Family Services - KRS 218A.010. Definitions for chapter.
www.lrc.ky.gov/Statutes/statute.aspx?id=44884

As used in this chapter:
(1) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by:
  (a) A practitioner or by his or her authorized agent under his or her immediate supervision and pursuant to his or her order; or
  (b) The patient or research subject at the direction and in the presence of the practitioner;
(2) "Anabolic steroid" means any drug or hormonal substance chemically and pharmacologically related to testosterone that promotes muscle growth and includes those substances listed in KRS 218A.090(5) but does not include estrogens, progestins, and anticosteroids;
(3) "Cabinet" means the Cabinet for Health and Family Services;
(4) "Child" means any person under the age of majority as specified in KRS 2.015;
(5) "Cocaine" means a substance containing any quantity of cocaine, its salts, optical and geometric isomers, and salts of isomers;
(6) "Controlled substance" means methamphetamine, or a drug, substance, or immediate precursor in Schedules I through V and includes a controlled substance analogue;
(7) (a) "Controlled substance analogue," except as provided in paragraph (b) of this subsection, means a substance:
    1. The chemical structure of which is substantially similar to the structure of a controlled substance in Schedule I or II; and
    2. Which has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or
    3. With respect to a particular person, which such person represents or intends to have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.
  (b) Such term does not include:

1. Any substance for which there is an approved new drug application;
2. With respect to a particular person, any substance if an exemption is in effect for investigational use for that person pursuant to federal law to the extent conduct with respect to such substance is pursuant to such exemption; or
3. Any substance to the extent not intended for human consumption before the exemption described in subparagraph 2. of this paragraph takes effect with respect to that substance;

(8) "Counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person who in fact manufactured, distributed, or dispensed the substance;

(9) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the packaging, labeling, or compounding necessary to prepare the substance for that delivery;

(10) "Dispenser" means a person who lawfully dispenses a Schedule II, III, IV, or V controlled substance to or for the use of an ultimate user;

(11) "Distribute" means to deliver other than by administering or dispensing a controlled substance;

(12) "Dosage unit" means a single pill, capsule, ampule, liquid, or other form of administration available as a single unit;

(13) "Drug" means:
   (a) Substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;
   (b) Substances intended for use in the diagnosis, care, mitigation, treatment, or prevention of disease in man or animals;
   (c) Substances (other than food) intended to affect the structure or any function of the body of man or animals; and
   (d) Substances intended for use as a component of any article specified in this subsection. It does not include devices or their components, parts, or accessories;

(14) "Good faith prior examination," as used in KRS Chapter 218A and for criminal prosecution only, means an in-person medical examination of the patient conducted by the prescribing practitioner or other health-care professional routinely relied upon in the ordinary course of his or her practice, at which time the patient is physically examined and a medical history of the patient is obtained. "In-person" includes telehealth examinations. This subsection shall not be applicable to hospice providers licensed pursuant to KRS Chapter 216B;

(15) "Hazardous chemical substance" includes any chemical substance used or intended for use in the illegal manufacture of a controlled substance as defined in this section or the illegal manufacture of methamphetamine as defined in KRS 218A.1431, which:
   (a) Poses an explosion hazard;
   (b) Poses a fire hazard; or
   (c) Is poisonous or injurious if handled, swallowed, or inhaled;

(16) "Heroin" means a substance containing any quantity of heroin, or any of its salts, isomers, or salts of isomers;

(17) "Hydrocodone combination product" means a drug with:
   (a) Not more than three hundred (300) milligrams of dihydrocodeinone, or any of its salts, per one hundred (100) milliliters or not more than fifteen (15) milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium; or
   (b) Not more than three hundred (300) milligrams of dihydrocodeinone, or any of its salts, per one hundred (100) milliliters or not more than fifteen (15) milligrams per dosage unit, with one (1) or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(18) "Immediate precursor" means a substance which is the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance or methamphetamine, the control of which is necessary to prevent, curtail, or limit manufacture;

(19) "Intent to manufacture" means any evidence which demonstrates a person's conscious objective to manufacture a controlled substance or methamphetamine. Such evidence includes but is not limited to statements and a chemical substance's usage, quantity, manner of storage, or proximity to other chemical substances or equipment used to manufacture a controlled substance or methamphetamine;

(20) "Isomer" means the optical isomer, except as used in KRS 218A.050(3) and 218A.070(1)(d). As used in KRS 218A.050(3), the term "isomer" means the optical, positional, or geometric isomer. As used in KRS 218A.070(1)(d), the term "isomer" means the optical or geometric isomer;

(21) "Manufacture," except as provided in KRS 218A.1431, means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container except that this term does not include activities:
   (a) By a practitioner as an incident to his or her administering or dispensing of a controlled substance in the course of his or her professional practice;
   (b) By a practitioner, or by his or her authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale; or
   (c) By a pharmacist as an incident to his or her dispensing of a controlled substance in the course of his or her professional practice;

(22) "Marijuana" means all parts of the plant Cannabis sp., whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin or any compound, mixture, or preparation which contains any quantity of these substances. The term "marijuana" does not include:
   (a) Industrial hemp as defined in KRS 260.850;
   (b) The substance cannabidiol, when transferred, dispensed, or administered pursuant to the written order of a physician practicing at a hospital or associated clinic affiliated with a Kentucky public university having a college or school of medicine; or
   (c) For persons participating in a clinical trial or in an expanded access program, a drug or substance approved for the use of those participants by the United States Food and Drug Administration;

(23) "Medical history," as used in KRS Chapter 218A and for criminal prosecution only, means an accounting of a patient's medical background, including but not limited to prior medical conditions, prescriptions, and family background;
(24) "Medical order," as used in KRS Chapter 218A and for criminal prosecution only, means a lawful order of a specifically identified practitioner for a specifically identified patient for the patient's health-care needs. "Medical order" may or may not include a prescription drug order;
(25) "Medical record," as used in KRS Chapter 218A and for criminal prosecution only, means a record, other than for financial or billing purposes, relating to a patient, kept by a practitioner as a result of the practitioner-patient relationship;
(26) "Methamphetamine" means any substance that contains any quantity of methamphetamine, or any of its salts, isomers, or salts of isomers;
(27) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:
    (a) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate;
    (b) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (a) of this subsection, but not including the isoquinoline alkaloids of opium;
    (c) Opium poppy and poppy straw;
    (d) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed;
    (e) Cocaine, its salts, optical and geometric isomers, and salts of isomers;
    (f) Ecgonine, its derivatives, their salts, isomers, and salts of isomers; and
    (g) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in paragraphs (a) to (f) of this subsection;
(28) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under KRS 218A.030, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms;
(29) "Opium poppy" means the plant of the species papaver somniferum L., except its seeds;
(30) "Person" means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity;
(31) "Physical injury" has the same meaning it has in KRS 500.080;
(32) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing;
(33) "Pharmacist" means a natural person licensed by this state to engage in the practice of the profession of pharmacy;
(34) "Practitioner" means a physician, dentist, podiatrist, veterinarian, scientific investigator, optometrist as authorized in KRS 320.240, advanced practice registered nurse as authorized under KRS 314.011, or other person licensed, registered, or otherwise permitted by state or federal law to acquire, distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in this state. "Practitioner" also includes a physician, dentist, podiatrist, veterinarian, or advanced practice registered nurse

authorized under KRS 314.011 who is a resident of and actively practicing in a state other than Kentucky and who is licensed and has prescriptive authority for controlled substances under the professional licensing laws of another state, unless the person's Kentucky license has been revoked, suspended, restricted, or probated, in which case the terms of the Kentucky license shall prevail;

(35) "Practitioner-patient relationship," as used in KRS Chapter 218A and for criminal prosecution only, means a medical relationship that exists between a patient and a practitioner or the practitioner's designee, after the practitioner or his or her designee has conducted at least one (1) good faith prior examination;

(36) "Prescription" means a written, electronic, or oral order for a drug or medicine, or combination or mixture of drugs or medicines, or proprietary preparation, signed or given or authorized by a medical, dental, chiropody, veterinarian, optometric practitioner, or advanced practice registered nurse, and intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;

(37) "Prescription blank," with reference to a controlled substance, means a document that meets the requirements of KRS 218A.204 and 217.216;

(38) "Presumptive probation" means a sentence of probation not to exceed the maximum term specified for the offense, subject to conditions otherwise authorized by law, that is presumed to be the appropriate sentence for certain offenses designated in this chapter, notwithstanding contrary provisions of KRS Chapter 533. That presumption shall only be overcome by a finding on the record by the sentencing court of substantial and compelling reasons why the defendant cannot be safely and effectively supervised in the community, is not amenable to community-based treatment, or poses a significant risk to public safety;

(39) "Production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance;

(40) "Recovery program" means an evidence-based, nonclinical service that assists individuals and families working toward sustained recovery from substance use and other criminal risk factors. This can be done through an array of support programs and services that are delivered through residential and nonresidential means;

(41) "Salvia" means Salvia divinorum or Salvinorin A and includes all parts of the plant presently classified botanically as Salvia divinorum, whether growing or not, the seeds thereof, any extract from any part of that plant, and every compound, manufacture, derivative, mixture, or preparation of that plant, its seeds, or its extracts, including salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation of that plant, its seeds, or extracts. The term shall not include any other species in the genus salvia;

(42) "Second or subsequent offense" means that for the purposes of this chapter an offense is considered as a second or subsequent offense, if, prior to his or her conviction of the offense, the offender has at any time been convicted under this chapter, or under any statute of the United States, or of any state relating to substances classified as controlled substances or counterfeit substances, except that a prior conviction for a nontrafficking offense shall be treated as a prior offense only when the subsequent offense is a nontrafficking offense. For the purposes of this

section, a conviction voided under KRS 218A.275 or 218A.276 shall not constitute a conviction under this chapter;

(43) "Sell" means to dispose of a controlled substance to another person for consideration or in furtherance of commercial distribution;

(44) "Serious physical injury" has the same meaning it has in KRS 500.080;

(45) "Synthetic cannabinoids or piperazines" means any chemical compound which is not approved by the United States Food and Drug Administration or, if approved, which is not dispensed or possessed in accordance with state and federal law, that contains Benzylpiperazine (BZP); Trifluoromethylphenylpiperazine (TFMPP); 1,1-Dimethylheptyl-11-hydroxytetrahydrocannabinol (HU-210); 1-Butyl-3-(1-naphthoyl)indole; 1-Pentyl-3-(1-naphthoyl)indole; dexanabinol (HU-211); or any compound in the following structural classes:

(a) Naphthoylindoles: Any compound containing a 3-(1-naphthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of this structural class include but are not limited to JWH-015, JWH-018, JWH-019, JWH-073, JWH-081, JWH-122, JWH-200, and AM-2201;

(b) Phenylacetylindoles: Any compound containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of this structural class include but are not limited to JWH-167, JWH-250, JWH-251, and RCS-8;

(c) Benzoylindoles: Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of this structural class include but are not limited to AM-630, AM-2233, AM-694, Pravadoline (WIN 48,098), and RCS-4;

(d) Cyclohexylphenols: Any compound containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of this structural class include but are not limited to CP 47,497 and its C8 homologue (cannabicyclohexanol);

(e) Naphthylmethylindoles: Any compound containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of this structural class include but are not limited to JWH-175, JWH-184, and JWH-185;

(f) Naphthoylpyrroles: Any compound containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of this structural class include but are not limited to JWH-030, JWH-145, JWH-146, JWH-307, and JWH-368;

(g) Naphthylmethylindenes: Any compound containing a 1-(1-naphthylmethyl)indene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of this structural class include but are not limited to JWH-176;

(h) Tetramethylcyclopropanoylindoles: Any compound containing a 3-(1-tetramethylcyclopropoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not further substituted in the tetramethylcyclopropyl ring to any extent. Examples of this structural class include but are not limited to UR-144 and XLR-11;

(i) Adamantoylindoles: Any compound containing a 3-(1-adamantoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the adamantyl ring system to any extent. Examples of this structural class include but are not limited to AB-001 and AM-1248; or

(j) Any other synthetic cannabinoid or piperazine which is not approved by the United States Food and Drug Administration or, if approved, which is not dispensed or possessed in accordance with state and federal law;

(46) "Synthetic cathinones" means any chemical compound which is not approved by the United States Food and Drug Administration or, if approved, which is not dispensed or possessed in accordance with state and federal law (not including bupropion or compounds listed under a different schedule) structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in one (1) or more of the following ways:

(a) By substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one (1) or more other univalent substituents. Examples of this class include but are not limited to 3,4-Methylenedioxycathinone (bk-MDA);

(b) By substitution at the 3-position with an acyclic alkyl substituent. Examples of this class include but are not limited to 2-methylamino-1-phenylbutan-1-one (buphedrone);

(c) By substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups, or by inclusion of the 2-amino nitrogen atom in a cyclic structure. Examples of this

class include but are not limited to Dimethylcathinone, Ethcathinone, and -Pyrrolidinopropiophenone (-PPP); or

(d) Any other synthetic cathinone which is not approved by the United States Food and Drug Administration or, if approved, is not dispensed or possessed in accordance with state or federal law;

(47) "Synthetic drugs" means any synthetic cannabinoids or piperazines or any synthetic cathinones;

(48) "Telehealth" has the same meaning it has in KRS 311.550;

(49) "Tetrahydrocannabinols" means synthetic equivalents of the substances contained in the plant, or in the resinous extractives of the plant Cannabis, sp. or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:

(a) Delta 1 cis or trans tetrahydrocannabinol, and their optical isomers;

(b) Delta 6 cis or trans tetrahydrocannabinol, and their optical isomers; and

(c) Delta 3, 4 cis or trans tetrahydrocannabinol, and its optical isomers;

(50) "Traffic," except as provided in KRS 218A.1431, means to manufacture, distribute, dispense, sell, transfer, or possess with intent to manufacture, distribute, dispense, or sell a controlled substance;

(51) "Transfer" means to dispose of a controlled substance to another person without consideration and not in furtherance of commercial distribution; and

(52) "Ultimate user" means a person who lawfully possesses a controlled substance for his or her own use or for the use of a member of his or her household or for administering to an animal owned by him or her or by a member of his or her household.

Effective: April 27, 2016

History: Amended 2016 Ky. Acts ch. 135, sec. 1, effective April 27, 2016. -- Amended 2014 Ky. Acts ch. 112, sec. 1, effective April 10, 2014. – Amended 2013 Ky. Acts ch. 26, sec. 1, effective March 19, 2013; and ch. 134, sec. 15, effective June 25, 2013. -- Amended 2012 Ky. Acts ch. 108, sec. 3, effective April 11, 2012. -- Amended 2011 Ky. Acts ch. 2, sec. 5, effective June 8, 2011; and ch. 45, sec. 15, effective March 16, 2011. -- Amended 2010 Ky. Acts ch. 85, sec. 42, effective July 15, 2010; ch. 149, sec. 4, effective April 13, 2010; and ch. 160, sec. 4, effective April 26, 2010. -- Amended 2009 Ky. Acts ch. 12, sec. 48, effective June 25, 2009. -- Amended 2007 Ky. Acts ch. 124, sec. 1, effective June 26, 2007. -- Amended 2006 Ky. Acts ch. 5, sec. 4, effective July 12, 2006. -- Amended 2005 Ky. Acts ch. 150, sec. 7, effective June 20, 2005; and ch. 99, sec. 527, effective June 20, 2005 -- Amended 2003 Ky. Acts ch. 51, sec. 3, effective June 24, 2003. -- Amended 1998 Ky. Acts ch. 301, sec. 12, effective July 15, 1998; and ch. 606, sec. 62, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 376, sec. 3, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 412, sec. 2, effective July 15, 1994. _ Amended 1992 Ky. Acts ch. 441, sec. 1, effective July 14, 1992. -- Amended 1974 Ky. Acts ch. 225, sec. 5, effective June 21, 1974 _ Created 1972 Ky. Acts ch. 226, sec. 2, effective July 1, 1972.

Legislative Research Commission Note (4/10/2014). 2014 Ky. Acts ch. 112, sec. 2 provided that the amendments made to this statute in Section 1 of that Act shall be known and may be cited as the "Clara Madeline Gilliam Act."

Legislative Research Commission Note (4/11/2012). Under the authority of KRS 7.136(1), the Reviser of Statutes has altered the format of the text in subsection (48) of this statute during codification. The words in the text were not changed.

Cabinet for Health and Family Services - 902 KAR 20:091. Facilities specifications, operation and services; community mental health center. www.lrc.ky.gov/kar/902/020/091reg.htm *(As Amended at ARRS, March 6, 2017)*

RELATES TO: KRS 17.500, 198B.260, 202A.011(4), 202B.010(6), 205.6313, 210.370, 210.410, 210.450, 216B.010, 216B.015, 216B.030, 216B.105, 216B.990, 222.211, 309.080, 309.130, 311.560*[(4)]*, 314.011(8), 314.042(8), 319.056, 319.064, 319C.010, 320.210(2), 335.080, 335.100, 335.300, 335.500, 439.3401, 645.020(5), *42 C.F.R. Part 2,* 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d-2 – 1320d-8, 42 U.S.C. 290ee-3

STATUTORY AUTHORITY: KRS 210.450(1), 216B.010, 216B.042, *216B.105*

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042 and 216B.105 require the Kentucky Cabinet for Health and Family Services to regulate health facilities and services. KRS 210.450(1) requires the secretary to promulgate administrative regulations to establish [prescribing] standards for qualification of personnel, quality of professional service, and personnel management operations. This administrative regulation establishes licensure requirements for the operation and services, and facility specifications of a community mental health center. In addition, this administrative regulation establishes standards for community mental health centers that elect to provide primary care services pursuant to KRS 210.410 and KRS 205.6313.

Section 1. Definitions.

(1) "Behavioral health professional" means:

(a) A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc. or the American Osteopathic Board of Neurology and Psychiatry;

(b) A physician licensed in Kentucky to practice medicine or osteopathy in accordance with KRS 311.571;

(c) A psychologist licensed and practicing in accordance with KRS 319.050;

(d) A certified psychologist with autonomous functioning or licensed psychological practitioner practicing in accordance with KRS 319.056;

(e) A clinical social worker licensed and practicing in accordance with KRS 335.100;

(f) An advanced practice registered nurse licensed and practicing in accordance with KRS 314.042;

(g) A psychiatric nurse as defined by subsection (22) of this section;

(h) A physician assistant licensed under KRS 311.840 to 311.862;

(i) A marriage and family therapist licensed and practicing in accordance with KRS 335.300;

(j) A professional clinical counselor licensed and practicing in accordance with KRS 335.500; or

(k) A licensed professional art therapist as defined by KRS 309.130(2).

(2) "Behavioral health professional under clinical supervision" means a:

(a) Psychologist certified and practicing in accordance with KRS 319.056;

(b) Licensed psychological associate licensed and practicing in accordance with KRS 319.064;

(c) Marriage and family therapist associate as defined by KRS 335.300(3);

(d) Social worker certified and practicing in accordance with KRS 335.080;

(e) Licensed professional counselor associate as defined by KRS 335.500(4); or

(f) Licensed professional art therapist associate as defined by KRS 309.130(3).

(3) "Center" means a community mental health center.

(4) "Certified alcohol and drug counselor" is defined by KRS 309.080(2).

(5) "Certified prevention specialist" means an individual who is currently certified as a certified prevention specialist by the Kentucky Certification Board for Prevention Professionals.

(6) "Client" means an individual described by KRS 210.410(2).

(7) "Community mental health center" means a program established pursuant to KRS Chapter 210.

(8) "Community support associate" means a paraprofessional who meets the application, training, and supervision requirements of 908 KAR 2:250.

(9)[(2) "Clinical psychologist" means a clinical psychologist certified or licensed pursuant to KRS 319.050(7), 319.056(2), (4), or 319.064(5).

(3)] "Crisis stabilization unit" means a community-based facility operated by or under contract with a center to provide emergency services as described in Section 8 of this administrative regulation to[no more than twelve (12)] clients who require overnight stays.

(10)[(4)] "Designated regional service area" means the geographical area to be served by the community mental health center.

(11) "Licensed assistant behavior analyst" is defined by KRS 319C.010(7).

(12) "Licensed behavior analyst" is defined by KRS 319C.010(6).

(13) "Licensed clinical alcohol and drug counselor" is defined by KRS 309.080(4).

(14) "Licensed clinical alcohol and drug counselor associate" is defined by KRS 309.080(5).

(15)[(5) "Licensed marriage and family therapist" means an individual licensed in accordance with KRS 335.300(2).

(6) "Licensed professional clinical counselor" means and individual licensed in accordance with KRS 335.500(3).

(7)] "Licensee" means the governing body legally responsible for the community mental health center.

(16) "Mechanical restraint" means any device attached or adjacent to a client's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

(17) "Mental health associate" means an individual who meets the mental health associate requirements established in the Community Mental Health Center Behavioral Health Services Manual incorporated by reference in 907 KAR 1:044, Section 13.

(18) "Patient" means a client, as described by KRS 210.410(2), or any other individual who seeks primary care services from a community mental health center.

(19) "Peer support specialist" means a paraprofessional who meets the application, training, examination, and supervision requirements of 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240.

(20)[(8)] "Plan of care" means a written plan that delineates the services to be provided to a client, and includes the short- and long-term goals of the plan.

(21) "Professional equivalent" means an individual who meets the professional equivalent requirements established in the Community Mental Health Center Behavioral Health Services Manual incorporated by reference in 907 KAR 1:044, Section 13.

(22)[(9)] "Psychiatric nurse" means a registered nurse who:

(a) Has a master's of science degree in nursing with a specialty in psychiatric or mental health nursing;

(b) Is a graduate of a four (4) year educational program with a bachelor of science degree in nursing and a minimum of one (1) year of experience in a mental health setting;

(c) Is a graduate of a three (3) year educational program with two (2) years of experience in a mental health setting; or

(d) Is a graduate of a two (2) year educational program with an associate degree in nursing and three (3) years of experience in a mental health setting.

(23) "Time out" means a treatment intervention that separates a client from others in a nonsecure area for a time-limited period to permit the client time to regain control over his or her behavior[(10) "Qualified social worker" means a social worker with a master's degree from an accredited school of social work who is licensed or exempt from licensure pursuant to KRS Chapter 335.

(11) "Time out" means a treatment intervention that separates a client from others in a nonsecure area for a time-limited period to permit the client time to regain control over his behavior].

Section 2. Scope of Operation and Services.

(1) A community mental health center:

(a) Shall provide a comprehensive range of accessible and coordinated behavioral health (mental health and substance abuse services) and[mental retardation] services for individuals with an intellectual or developmental disability, including direct or indirect[mental health or mental retardation] services[,] to the population of a designated regional service area, as required by KRS 210.370 to 210.480; and

(b) May provide primary care services:

1. As permitted by KRS 210.410; and

2. In accordance with the requirements established in Section 7 of this administrative regulation.

(2) A center's services, including primary care services if provided, shall be available to the client population described by KRS 210.410(2).

Section 3. Administration and Operation.

(1) Licensee.

(a) The licensee shall be legally responsible for:

1. The center;

2. The establishment of administrative policy; and

3. Compliance with federal, state, and local law pertaining to the operation of the center.

(b) To obtain or renew a license to operate a center, the licensee shall comply with the requirements of this administrative regulation and the requirements of relevant statutes and administrative regulations.

(2) Executive director. The licensee shall designate an executive director, qualified by training and experience, who shall be responsible for:

(a) The total program of the center and its affiliates in accordance with the center's written policies; and

(b) Evaluation of the program as it relates to the client's needs.

(3) Policies. The licensee shall establish written policies for the administration and operation of the center, which shall be available to staff and which shall include:

(a) A description of the organizational structure specifying the:

1. Responsibility, function, and interrelations of each organizational unit;[,] and

2.[the] Lines of administrative and clinical authority;

(b) The appropriate method and procedure for storage, dispensing, and administering of a drug or biological agent;

(c) Client grievance procedure;

(d) Confidentiality and use of client records in accordance with federal, state, and local statutes and regulations, including subsection (4) of this section; and

(e) Personnel policy, including:

1. A job description and qualifications for each personnel category;

2. Wage scale, hours of work, vacation and sick leave;

3. A plan for orientation of personnel to the policies and objectives of the center,[and for] on-the-job training, if necessary, and ongoing in-service training programs related to the employee's job activities; and

4. Annual[Periodic] evaluation of employee performance.

(4) Client records. A client record shall be maintained for each individual receiving services.

(a) Each entry shall be current, dated, signed, and indexed according to the service received.[;]

(b) Ownership.

1. Client records shall be the property of the center.

2. The original client record shall not be removed from the center except by court order or subpoena.

3. Copies of a client record or portions of the record may be used and disclosed as established by paragraph (d) of this subsection.

(c) A client record shall be retained for at least six (6)[five (5)] years or, in the case of a minor, three (3) years after the client reaches the age of majority, whichever is longer.

(d) Confidentiality and security: use and disclosure.

1. The center shall maintain the confidentiality and security of client records in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d-2 to 1320-8, and 45 C.F.R. Parts 160 and 164, as amended, including the security requirements mandated by Subparts A and C of 45 C.F.R. Part 164, or as provided by applicable federal or state law, including 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

2. The center may use and disclose client records. Use and disclosure shall be as established or required by:

a. HIPAA, 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164; or

b. 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

3. A center may establish higher levels of confidentiality and security than required by HIPAA, 42 U.S.C. 1320d-2 to 1320-8, and 45 C.F.R. Parts 160 and 164, or 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

(e)[; (c) Each client record shall be kept in a locked file and treated as confidential. Information contained in a client record shall:

1. Be disclosed to an authorized person; and
2. Not be disclosed to an unauthorized person;

(d)] Each client record shall contain:

1. An identification sheet;
2. Information on the purpose for seeking a service;
3. A history of findings and treatments rendered;
4. Screening information pertaining to the problem;
5. Staff notes on services provided;
6. Pertinent medical, psychiatric, and social information;
7. Disposition;
8. Assigned status;
9. Assigned personnel[therapists]; and
10. A termination summary[study] recapitulating findings and events during treatment, clinical impressions, and condition on termination.

Section 4. Staff Requirements.

(1)[(5) Personnel.] A community mental health center shall employ the following full-time personnel:

(a) An executive director as required by Section 3(2) of this administrative regulation who:

1. May serve in a dual role as the center's program director;
2. Shall meet the education requirements established by the center's governing board for the executive director, or have a master's degree in business administration or a human services field or a bachelor's degree in a human services field, including:

a. Social work;
b. Sociology;
c. Psychology;
d. Guidance and counseling;
e. Education;
f. Religion;
g. Business administration;
h. Criminal justice;
i. Public administration;
j. Child care administration;
k. Christian education;
l. Divinity;
m. Pastoral counseling;
n. Nursing;
o. Public health; or
p. Another human service field related to working with children with severe emotional disabilities or clients with severe mental illness; and

3.a. Shall have two (2) years of prior supervisory experience in a human services program for an executive director with a master's degree;

b. Shall have a minimum of two (2) years of prior experience in a human services program plus two (2) years of prior supervisory experience in a human services program for an executive director with a bachelor's degree; or

c. Shall meet the experience requirements established by the center's governing board for the executive director;

(b)[1.] A program director who:

1. Shall be a:

a. Psychiatrist;

b. Certified[or licensed] psychologist with autonomous functioning, licensed psychological practitioner, or licensed psychologist;

c. Psychiatric nurse;

d. Licensed professional clinical counselor;

e. Licensed marriage and family therapist; or

f. Licensed clinical[Qualified] social worker or certified social worker;

2. May serve as[. 2. The program director may be] the executive director; and

3. Shall be responsible for maintenance of the center's therapeutic milieu;

(c) A medical director[(b)1. A board-certified or board-eligible psychiatrist] who shall:

1. Be a board certified or board eligible psychiatrist licensed in the state of Kentucky;

2.[a.] Be responsible for treatment planning; and

3.[b. Provide psychiatric service as indicated by client needs; and

c.] Supervise and coordinate the provision of psychiatric services by the center;

(d) A licensed psychologist or licensed psychological practitioner pursuant to KRS 319.050, 319.056, or 319.064;

(e) A sufficient number of personnel to provide services as described in Section 5 of this administrative regulation; and

(f) A records librarian or a designated staff person who shall assure that client records are maintained and that information is immediately retrievable.

(2) Background checks.

(a) The executive director and all personnel of a center shall:

1. Have a criminal record check performed upon initial hire through the Administrative Office of the Courts or the Kentucky State Police;

2. Not have a criminal conviction or plea of guilty to a:

a. Sex crime as specified in KRS 17.500;

b. Violent crime as specified in KRS 439.3401;

c. Criminal offense against a minor as specified in KRS 17.500; or

d. Class A felony; and

3. Not be listed on the following:

a. Central registry established by 922 KAR 1:470;

b. Nurse aide or home health aide abuse registry established by 906 KAR 1:100; or

c. Caregiver misconduct registry established by 922 KAR 5:120.

(b) A center may use the Kentucky national background check program established by 906 KAR 1:190 to satisfy the background check requirements of paragraph (a) of this subsection.

(c) A center shall perform annual criminal record and registry checks as described in paragraph (a) of this subsection on a random sample of at least fifteen (15) percent of all personnel who have not been subject to the annual background check during the previous three (3) year period.

(d) A center may use the Kentucky national background check program established by 906 KAR 1:190 to satisfy the annual background check requirements of paragraph (c) of this subsection upon implementation of the continuous assessment service, also referred to as rap back.[2. This position may be filled by more than one (1) psychiatrist if the total hours worked are equivalent to one (1) full-time position;

(c) A clinical psychologist who shall provide evaluation and screening services for the client and individual or group therapy;

(d) A licensed professional clinical counselor who shall provide evaluation and screening services for the client and individual or group therapy;

(e) A licensed marriage and family therapist who shall provide evaluation and screening services for the client and individual or group therapy;

(f) A psychiatric nurse who shall provide or supervise nursing service for psychiatric care;

(g) A qualified social worker who shall provide social services as required; and

(h) A person who shall assure that client records are maintained and that information is immediately retrievable.]

Section 5[4]. Services.

(1) The center shall provide services in the designated regional service area directly or through contract.

(2) Direct services. The center shall provide services as described in subsection (4) of this section and offer a sufficiently wide range of treatment to meet client needs, which may include behavioral health services described in subsection (5) of this section[including:

(a) Individual therapy;

(b) Family therapy;

(c) Group therapy;

(d) Play therapy;

(e) Behavior modification; and

(f) Chemotherapy].

(3) Plan of care.

(a) Each client receiving direct treatment under the auspices of a community mental health center shall have an individual plan of care signed by an independently licensed behavioral health professional[a clinically licensed or certified professional provider of the treatment].

(b) A medical service, including a change of medication, a diet restriction, or a restriction on physical activity shall be ordered by a physician or other ordering practitioner acting within the limits of his or her statutory scope of practice.

(4) The center shall provide:

(a) Partial hospitalization or psychosocial rehabilitation services pursuant to KRS 210.410(1)(c)[A therapeutic program for a person who requires less than twenty-four (24) hour a day care, and more than outpatient care (i.e., partial hospitalization or day care)]. A psychiatrist shall be present on a regularly scheduled basis to provide consultant services to staff;

(b)1. Inpatient services pursuant to KRS 210.410(1)(a) through affiliation with a licensed[community] hospital for a person requiring full-time inpatient care; or

2. If the[. A] center[that] does not have an affiliation contract in effect, documentation of[shall be considered to be in compliance with this requirement if the center documents] a good faith effort to enter into an affiliation contract;

(c) Outpatient services pursuant to KRS 210.410(1)(b)[service] on a regularly scheduled basis with arrangements made for a nonscheduled visit during a time of increased stress or crisis. The outpatient service shall provide diagnosis and evaluation of a psychiatric problem and a referral to other services or agencies as indicated by the client's needs;

(d) Emergency services pursuant to KRS 210.410(1)(d)[service] for the immediate evaluation and care of a person in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis. All components of the emergency service shall be coordinated into a unified program that enables a client receiving an emergency service to be readily transferred to another service of the center as client needs dictate; and

(e) Consultation and education services pursuant to KRS 210.410(1)(e) for individuals,[for an individual and various] community agencies, and groups to increase the visibility, identifiability, and accessibility of the center and to promote services for intellectual disabilities and mental health disorders, substance use disorders, or co-occurring disorders[through the distribution of relevant mental health knowledge].

(5) Rehabilitative mental health and substance use services, which may be provided by a center in accordance with a plan of care, include the following:

(a) Screening that shall be provided by a behavioral health professional, behavioral health professional under clinical supervision, professional equivalent, mental health associate, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice to determine the:

1. Likelihood that an individual has a mental health, substance use, or co-occurring disorder; and

2. Need for an assessment;

(b) Assessment that shall:

1. Be provided by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, professional equivalent, mental health associate, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice who gathers information and engages in a process with the client, thereby enabling the professional to:

a. Establish the presence or absence of a mental health, substance use, or co-occurring disorder;

b. Determine the client's readiness for change;

c. Identify the client's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the client in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinical disorder or service need;

3. Include working with the client to develop a plan of care if a clinical disorder or service need is assessed; and

4. Not include psychological or psychiatric evaluations or assessments;

(c) Psychological testing that shall:

1. Be performed by a licensed psychologist, licensed psychological associate, licensed psychological practitioner, or an individual who meets the requirements of KRS Chapter 319 related to the necessary credentials to perform psychological testing; and

2. Include a psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities, and interpretation and written report of testing results;

(d) Crisis intervention that:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to the client or another individual;

2. Shall consist of clinical intervention and support services necessary to provide:

a. Integrated crisis response;

b. Crisis stabilization interventions; or

c. Crisis prevention activities;

3. Shall be provided:

a. On-site at the center;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter;

4. May be provided as a telehealth consultation;

5. May include:

a. Verbal de-escalation;

b. Risk assessment; or

c. Cognitive therapy;

6. Shall be provided by a:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Professional equivalent;

d. Mental health associate;

e. Certified alcohol and drug counselor;

f. Licensed clinical alcohol and drug counselor; or

g. Licensed clinical alcohol and drug counselor associate;

7. Shall be followed by a referral to non-crisis services, if applicable; and

8. May include:

a. Further service prevention planning, including:

(i) Lethal means reduction for suicide risk; or

(ii) Substance use disorder relapse prevention; or

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

(e) Mobile crisis services that shall:

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

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

3. Not be an overnight service;

4. Be a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports to:

a. Reduce symptoms or harm; or

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

5. Involve all services and supports necessary to provide:

a. Integrated crisis prevention;

b. Assessment and disposition;

c. Intervention;

d. Continuity of care recommendations; and

e. Follow-up services;

6. Be provided face-to-face in a home or community setting by a:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Professional equivalent;

d. Mental health associate;

e. Certified alcohol and drug counselor;

f. Licensed clinical alcohol and drug counselor; or

g. Licensed clinical alcohol and drug counselor associate; and

7. Ensure 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;

(f) Day treatment that shall:

1. Be a nonresidential, intensive treatment program designed for youth who:

a. Have a substance use disorder, mental health disorder, or co-occurring disorder;

b. Are under twenty-one (21) years of age; and

c. Are at high risk of out-of-home placement due to a behavioral health issue;

2. Consist of an organized, behavioral health program of treatment and rehabilitative services for substance use disorder, mental health disorder, or a co-occurring disorder;

3. Have unified policies and procedures that address:

a. The program's philosophy;

b. Admission and discharge criteria;

c. Admission and discharge process;

d. Staff training; and

e. Integrated case planning;

4. Include the following:

a. Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

b. Behavior management and social skill training;

c. Independent living skills that correlate to the age and development stage of the client; and

d. Services designed to explore and link with community resources before discharge and to assist the client and family with transition to community services after discharge;

5. Be provided as follows:

a. 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);

b. On school days and during scheduled school breaks;

c. In coordination with the child's individual educational plan or Section 504 plan if the child has an individual educational plan or Section 504 plan;

d. By personnel that includes the following practicing within his or her scope of practice:
(i) Behavioral health professional;
(ii) Behavioral health professional under clinical supervision;
(iii) Professional equivalent;
(iv) Mental health associate;
(v) Certified alcohol and drug counselor;
(vi) Licensed clinical alcohol and drug counselor;
(vii) Licensed clinical alcohol and drug counselor associate; or
(viii) Peer support specialist; and

e. According to a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider; and

6. Not include a therapeutic clinical service that is included in a child's individualized education plan;

(g) Peer support that shall:

1. Be provided by a peer support specialist;

2. Be structured and scheduled nonclinical therapeutic activity with a client or group of clients;

3. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills; and

4. Be identified in the client's plan of care;

(h) Intensive outpatient program services that shall:

1. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;

2. Be provided at least three (3) hours per day at least three (3) days per week;

3. Include the following:

a. Individual outpatient therapy;

b. Group outpatient therapy;

c. Family outpatient therapy unless contraindicated;

d. Crisis intervention; or

e. Psycho-education during which the client or client's family member shall be:

(i) Provided with knowledge regarding the client'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 client's diagnosis or condition in a successful manner;

4. Include a treatment plan that shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lower level of care;

5. Be provided by the following practicing within his or her scope of practice:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Professional equivalent;

d. Mental health associate; or

e. Certified alcohol and drug counselor;

6. Include access to a board-certified or board-eligible psychiatrist for consultation;

7. Include access to a psychiatrist, other physician, or advanced practice registered nurse for medication prescribing and monitoring; and

8. Be provided in a setting with a minimum client-to-staff ratio of ten (10) clients to one (1) staff person;

(i) Individual outpatient therapy that shall:

1. Be provided to promote the:

a. Health and well-being of the client; or

b. Recovery from a substance related disorder;

2. Consist of a face-to-face therapeutic intervention with the client provided in accordance with the client's plan of care, which may be provided as a telehealth consultation;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the client; and

c. Improving functioning;

4. Not exceed three (3) hours per day; and

5. Be provided by the following personnel practicing within his or her scope of practice:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Licensed behavior analyst;

d. Licensed assistant behavior analyst working under the supervision of a licensed behavior analyst;

e. Professional equivalent;

f. Mental health associate;

g. Certified alcohol and drug counselor;

h. Licensed clinical alcohol and drug counselor; or

i. Licensed clinical alcohol and drug counselor associate;

(j) Group outpatient therapy that shall:

1. Be provided to promote the:

a. Health and well-being of the client; or

b. Recovery from a substance related disorder;

2. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the client's plan of care, and which may be provided as a telehealth consultation;

3. Excluding multi-family group therapy, be provided in a group setting of nonrelated individuals, not to exceed twelve (12) individuals in size. For group outpatient therapy, a nonrelated individual means any individual who is not a:

a. Spouse;

b. Significant other;

c. Parent or person with custodial control;

d. Child;

e. Sibling;

f. Stepparent;

g. Stepchild;

h. Step-brother;

i. Step-sister;

j. Father-in-law;

k. Mother-in-law;

l. Son-in-law;
m. Daughter-in-law;
n. Brother-in-law;
o. Sister-in-law;
p. Grandparent; or
q. Grandchild;
4. Focus on the psychological needs of the client as evidenced in the client's plan of care;
5. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
6. Not include:
a. Physical exercise;
b. A recreational activity;
c. An educational activity; or
d. A social activity;
7. Not exceed three (3) hours per day per client unless additional time is medically necessary in accordance with 907 KAR 3:130;
8. Ensure that the group has a deliberate focus and defined course of treatment;
9. Ensure that the subject of group outpatient therapy shall be related to each client participating in the group; and
10. Be provided by one (1) or more of the following personnel practicing within his or her scope of practice, and who shall maintain individual notes regarding each client within the group in the client's record:
a. Behavioral health professional;
b. Behavioral health professional under clinical supervision;
c. Licensed behavior analyst;
d. Licensed assistant behavior analyst working under the supervision of a licensed behavior analyst;
e. Professional equivalent;
f. Mental health associate;
g. Certified alcohol and drug counselor;
h. Licensed clinical alcohol and drug counselor; or
i. Licensed clinical alcohol and drug counselor associate;
(k) Family outpatient therapy that shall:
1. Consist of a face-to-face behavioral health therapeutic intervention, which may be provided as a telehealth consultation, and shall be provided through scheduled therapeutic visits between the therapist, the client unless the corresponding current procedural terminology code establishes that the recipient is not present, and at least one (1) member of the client's family;
2. Address issues interfering with the relational functioning of the family;
3. Seek to improve interpersonal relationships within the client's home environment;
4. Be provided to promote the health and well-being of the client or recovery from a substance use disorder;
5. Not exceed three (3) hours per day per client unless additional time is medically necessary in accordance with 907 KAR 3:130; and
6. Be provided by the following personnel practicing within his or her scope of practice:

a. Behavioral health professional;
b. Behavioral health professional under clinical supervision;
c. Professional equivalent;
d. Mental health associate;
e. Certified alcohol and drug counselor;
f. Licensed clinical alcohol and drug counselor; or
g. Licensed clinical alcohol and drug counselor associate;

(l) Collateral outpatient therapy that shall consist of a face-to-face behavioral health consultation on behalf of a client under the age of twenty-one (21) and may be provided as a telehealth consultation:

1. With a:
a. Parent;
b. Caregiver;
c. Person who has custodial control;
d. Household member;
e. Legal representative;
f. School staff person; or
g. Treating professional;
2. Provided by the following personnel practicing within his or her scope of practice:
a. Behavioral health professional;
b. Behavioral health professional under clinical supervision;
c. Licensed behavior analyst;
d. Licensed assistant behavior analyst working under the supervision of a licensed behavior analyst;
e. Professional equivalent;
f. Mental health associate;
g. Certified alcohol and drug counselor;
h. Licensed clinical alcohol and drug counselor; or
i. Licensed clinical alcohol and drug counselor; and
3. Provided upon the written consent of a parent, caregiver, or person who has custodial control of a client under the age of twenty-one (21). Documentation of written consent shall be signed and maintained in the client's record;

(m) Service planning that shall be provided by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, professional equivalent, or mental health associate to:

1. Assist a client in creating an individualized plan for services needed for maximum reduction of the effects of a mental health disorder;
2. Restore a client's functional level to the client's best possible functional level; and
3. Develop a service plan that:
a. Shall be directed by the client; and
b. May include:
(i) A mental health advance directive being filed with a local hospital;
(ii) A crisis plan; or
(iii) A relapse prevention strategy or plan;

(n) Screening, brief intervention, and referral to treatment for substance use disorders that shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use prior to the need for more extensive or specialized treatment;

2. Consist of:

a. Using a standardized screening tool to assess the individual for risky substance use behavior;

b. Engaging a client who demonstrates risky substance use behavior in a short conversation, providing feedback and advice; and

c. Referring the client to therapy or other services that address substance use if the client is determined to need additional services; and

3. Be provided by the following personnel practicing within his or her scope of practice:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Professional equivalent;

d. Mental health associate;

e. Certified alcohol and drug counselor;

f. Licensed clinical alcohol and drug counselor;

g. Licensed clinical alcohol and drug counselor associate; or

h. Certified prevention specialist;

(o) Assertive community treatment for mental health disorders that shall:

1. Include:

a. Assessment;

b. Treatment planning;

c. Case management;

d. Psychiatric services;

e. Medication prescribing and monitoring;

f. Individual and group therapy;

g. Peer support;

h. Mobile crisis services;

i. Mental health consultation;

j. Family support; and

k. Basic living skills;

2. Be provided by a multidisciplinary team of at least four (4) professionals, including:

a. A psychiatrist;

b. A nurse;

c. A case manager;

d. A peer support specialist; and

e. Any other behavioral health professional, behavioral health professional under clinical supervision, professional equivalent, or mental health associate; and

3. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team member;

(p) Comprehensive community support services that shall:

1. Consist of activities needed to allow an individual with a mental health disorder to live with maximum independence in the community through the use of skills training as identified in the client's treatment plan;

2. Consist of using a variety of psychiatric rehabilitation techniques to:

a. Improve daily living skills;

b. Improve self-monitoring of symptoms and side effects;

c. Improve emotional regulation skills;

d. Improve crisis coping skills; and

e. Develop and enhance interpersonal skills; and

3. Be provided by a:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Community support associate;

d. Licensed behavior analyst;

e. Licensed assistant behavior analyst working under the supervision of a licensed behavior analyst;

f. Professional equivalent; or

g. Mental health associate;

(q) Therapeutic rehabilitation program for an adult with a severe mental illness or child with a severe emotional disability that shall:

1. Include services designed to maximize the reduction of mental illness or emotional disability and restoration of the client's functional level to the individual's best possible functioning;

2. Establish the client's own rehabilitative goals within the person-centered plan of care;

3. Be delivered using a variety of psychiatric rehabilitation techniques focused on:

a. Improving daily living skills;

b. Self-monitoring of symptoms and side effects;

c. Emotional regulation skills;

d. Crisis coping skills; and

e. Interpersonal skills; and

4. Be provided individually or in a group by a:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Peer support specialist;

d. Professional equivalent; or

e. Mental health associate;

(r) Partial hospitalization that shall:

1. Be provided by the following practicing within his or her scope of practice:

a. Behavioral health professional;

b. Behavioral health professional under clinical supervision;

c. Professional equivalent;

d. Mental health associate; or

e. Certified alcohol and drug counselor;

2. Be a short-term (average of four (4) to six (6) weeks), less than twenty-four (24) hour, intensive treatment program for an individual who is experiencing significant impairment to daily functioning due to substance use disorder, mental health disorder, or co-occurring disorder;

3. Be provided to an adult or a child;

4. Ensure that admission criteria for partial hospitalization is based on an inability to adequately treat the individual through community-based therapies or intensive outpatient services;

5. Consist of individual outpatient therapy, group outpatient therapy, family outpatient therapy, or medication prescribing and monitoring;

6. Typically be provided for at least four (4) hours per day and focused on one (1) primary presenting problem, which may include substance use, sexual reactivity, or another problem; and

7. Include the following personnel for the purpose of providing medical care if necessary:

a. An advanced practice registered nurse;

b. A physician assistant or physician available on site; and

c. A board-certified or board-eligible psychiatrist available for consultation;

(s) Residential treatment services for substance use disorders as described in Section 6 of this administrative regulation;

(t) Targeted case management services that shall:

1. Include services to one (1) or more of the following target groups:

a. An adult or a child with substance use disorder;

b. An adult or child with co-occurring mental health or substance use disorder and chronic or complex physical health issues;

c. A child with a severe emotional disability; or

d. An adult with severe mental illness;

2. Be provided by a case manager who meets the requirements of 908 KAR 2:260; and

3. Include the following assistance:

a. Comprehensive assessment and reassessment of client needs to determine the need for medical, educational, social, or other services. The reassessment shall be conducted annually or more often if needed based on changes in the client's condition;

b. Development of a specific care plan that shall be based on information collected during the assessment and revised if needed upon reassessment;

c. Referral and related activities, which may include:

(i) Scheduling appointments for the client to help the individual obtain needed services; or

(ii) Activities that help link the client with medical, social, educational providers, or other programs and services that address identified needs and achieve goals specified in the care plan;

d. Monitoring, which shall be face-to-face and occur no less than once every three (3) months to determine that:

(i) Services are furnished according to the client's care plan;

(ii) Services in the care plan are adequate; and

(iii) Changes in the needs or status of the client are reflected in the care plan; and

e. Contacts with the client, family members, service providers, or others are conducted as frequently as needed to help the client:

(i) Access services;

(ii) Identify needs and supports to assist the client in obtaining services; and

(iii) Identify changes in the client's needs; or

(u) Pregnant women substance use prevention services or substance use case management services.

(6) Quality assurance and utilization review.

(a) The center shall have an on-going, written quality assurance and[a] utilization[and] review program that:

1. Includes effective mechanisms for reviewing and evaluating client care and, if applicable, patient care in order to identify problems or opportunities to improve care;

2. Provides for appropriate responses to findings;

3. Assigns responsibility for monitoring and evaluating client and, if applicable, patient care;

4. Delineates the scope of care provided by the center;

5. Identifies the aspects of care that the center provides;

6. Identifies indicators and appropriate clinical criteria that can be used to monitor these aspects of care;

7. Collects and organizes data for each indicator;

8. Contains written procedures for taking appropriate corrective action;

9. Assesses the effectiveness of the actions taken to correct problems and documents the improvement in care; and

10. Communicates relevant information to other individuals, departments, or services as to the quality assurance program[plan for the evaluation of the service needs of each client].

(b) The need for continuing services[a service element for each individual] shall be evaluated immediately upon a change in a client's service needs or a change in the client's condition[with sufficient frequency] to ensure that proper arrangements have been made for:

1. Discharge;

2.[, for] Transfer;[to other elements of service,] or

3. Referral to another service provider, if appropriate.

(7)[(6)] Medications.

(a)1. If a center uses electronic prescribing, the center shall maintain a paper copy of each prescription.

2. If a center does not use electronic prescribing, the center shall document each prescription on a form designated specifically for medications.[A treatment involving medication or chemotherapy shall be administered under the direction of a licensed physician or other qualified practitioner, acting within the scope of his practice, and:

(a) Medication or chemotherapy used in treatment shall be recorded in the staff notes on a special medications chart in the client record;]

(b) Documentation[A copy] of the prescription shall be kept in the client record.[;]

(c) Blood or another laboratory test or examination shall be performed in accordance with accepted medical practice.[on each individual receiving medication prescribed or administered by the center;]

(d) Drug supplies shall be stored under proper sanitary, temperature, light, and moisture conditions.[;]

(e) Medication kept by the center shall be properly labeled.[;]

(f) A medication shall be stored in the originally received container unless transferred to another container by a pharmacist or another person licensed to transfer the medication.[; and]

(g) Medication kept in the center shall be kept in a locked cabinet.

1. A controlled substance shall be kept under double lock (e.g., in a locked box in a locked cabinet).

2. There shall be a controlled substances record, in which is recorded:

a. The name of the patient;

b. The date, time, dosage, balance remaining, and method of administration of each controlled substance;

c. The name of the prescribing physician or other ordering practitioner acting within the limits of his statutory scope of practice; and

d. The name of the nurse who administered it, or staff who supervised the self-administration.

3. Except for medication to be self-administered in a crisis stabilization unit, access to the locked cabinet shall be restricted to a designated medication nurse or other authorized personnel. Medication to be self-administered in a crisis stabilization unit shall be made available to the patient at the time of administration.

Section 6. Residential Treatment Services for Substance Use Disorders.

(1) If a center licensed under this administrative regulation provides residential services to clients with a substance use disorder, the center shall obtain separate licensure as a residential alcohol and other drug abuse treatment program pursuant to 908 KAR 1:370.

(2) In addition to meeting the requirements of 908 KAR 1:370 for residential treatment programs, a center that provides residential services for substance use disorders shall:

(a) Provide intensive treatment and skills building in a structured and supportive environment;

(b) Assist the client in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

(c) Provide services in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed at treating individuals with addiction or co-occurring mental health and substance use disorders;

(d) Assist the client in making necessary changes to enable the individual to live drug- or alcohol-free;

(e) Provide services under the medical direction of a physician; and

(f) Provide continuous nursing services in which a registered nurse shall be:

1. On-site during traditional first shift hours, Monday through Friday;

2. Continuously available by phone after hours; and

3. On-site as needed in follow-up to telephone consultation after hours.

Section 7. Primary Care Services.

(1) Basic services. The center may provide a variety of preventive, medical diagnostic, laboratory, x-ray, treatment, and therapeutic (physical, occupational, and speech therapy) services by appropriately licensed or certified health professionals to meet the usual physical health care needs of:

(a) The center's clients as described by KRS 210.410(2) to help ensure continuity of care; and

(b) Other individuals seeking primary care services from the center.

(2) Referrals. If a center provides primary care services to its clients, the center shall provide appropriate referrals for clients who require services that are above the level of basic primary care services not provided by the center.

(3) Policies.

(a) Administrative policies. A center that provides primary care services shall have written administrative policies in addition to the requirement established in Section 3(3) of this administrative regulation, including:

1. A description of organizational structure for the delivery of primary care services, which may include therapeutic services, staffing, and allocation of responsibility and accountability;

2. A description of referral linkages with inpatient facilities and other providers;

3. Policies and procedures for the guidance and control of personnel performances;

4. A description of primary care and therapeutic services directly provided by the center, which may include the provision of services in a home- or community-based setting;

5. A description of the administrative and patient health records and reports; and

6. A policy to specify the provision of emergency medical services.

(b) Patient care policies.

1. Patient care policies shall be developed by the center's medical director required by subsection (4)(b) of this section and other professional staff for all medical aspects of the center's program, including written protocols for standing orders, rules of practice, and medical directives that apply to services provided by the center.

2. The protocols shall be signed by the medical director.

3. A system shall be established to ensure that, if feasible, the patient shall be always cared for by the same health professional or health team, to assure continuity of care.

(c) Patient rights policies. The center shall adopt written policies regarding the rights and responsibilities of patients. These patient rights policies shall assure that each patient shall be:

1. Informed of these rights and of all rules and requirements of 902 KAR Chapter 20 governing patient conduct and responsibilities, including a procedure for allowing the patient to voice a grievance or recommend changes in policies and services. Upon the patient's request, a grievance or recommendation shall be conveyed within a reasonable time to a decision making level within the organization with the authority to take corrective action;

2. Informed of services available at the center;

3. Informed of his or her medical condition, unless medically contraindicated as documented in his or her health record;

4. Afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;

5. Encouraged and assisted to understand and exercise his or her patient rights;

6. Assured confidential treatment of his or her records and shall be afforded the opportunity to approve or refuse release of the records to any individual not involved in the patient's care, except as required by applicable law or third-party payment contract; and

7. Treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and in the care of his or her personal health needs.

(4) Personnel.

(a) Primary care provider team. Each center that provides primary care services shall be staffed with at least:

1. One (1) full-time advanced practice registered nurse or physician assistant;

2. One (1) physician who:

a. Except in extraordinary circumstances as documented in the center's records, shall be present no less than once in every two (2) week period to provide medical direction, medical care services, consultation, and supervision; and

b. Shall be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. If a center is staffed with a full-time physician who provides medical care services on-site, the requirement for at least one (1) full-time advanced practice registered nurse or physician assistant shall be waived; and

3. Core staff of appropriately licensed or certified health professionals as necessary to carry out services provided.

(b) Medical Director. A medical director responsible for oversight of a center's primary care services shall:

1. Be a licensed physician;

2. Be responsible for all physical health aspects of the center;

3. Provide direct medical services in accordance with the Medical Practice Act, KRS Chapter 311; and

4. If the medical director responsible for the physical health aspects of the center is not a board certified or board eligible psychiatrist licensed in Kentucky, coordinate care and treatment decisions with the center's psychiatrist for all primary care services delivered to the center's clients.

(c) Physicians. A physician employed by or under contract with the center to perform services as described in paragraph (a)2 of this subsection shall be:

1. Qualified to practice general medicine, including as a general practitioner, family practitioner, obstetrician – gynecologist, pediatrician, or internist; and

2. A member of the medical staff or hold courtesy staff privileges at one (1) or more hospitals with which the center has a formal transfer agreement.

(d) In-service training.

1. All center personnel who provide primary care services shall participate in ongoing in-service training programs relating to their respective job activities.

2. The training programs shall include:

a. Thorough job orientation for new personnel;

b. Regular in-service training emphasizing professional competence and the human relationship necessary for effective health care; and

c. On-the-job training, if necessary.

(5)(a) The confidentiality and retention of client records shall be maintained in accordance with Section 3(4) of this administrative regulation.

(b) The center shall maintain a health record for each patient. The health record shall include:

1. The patient's medical and social history, including data obtained from other providers;

2. A description of each primary care visit or contact, including the condition or reason necessitating the visit or contact, assessment, diagnosis, services provided, medications and treatments prescribed, and disposition made;

3. Reports of all laboratory, x-ray, and other test findings; and

4. Documentation of all referrals made, including the reason for the referral, to whom the patient was referred, and any information obtained from the referral source.

(c) Transfer of records. The center shall:

1. Establish systematic procedures to assist in continuity of care if the patient moves to another source of care; and

2. Upon proper release, transfer health records or an abstract if requested.

(6) Linkage agreements.

(a) The center shall have linkages through written agreements with providers of other levels of care that may be medically indicated to supplement the services available in the center. These linkages shall include:

1. Hospitals; and

2. Emergency medical transportation services in the service area.

(b) Linkage agreements with inpatient care facilities shall incorporate provisions for:

1. Appropriate referral and acceptance of patients from the center;

2. Appropriate coordination of discharge planning with center staff; and

3. The discharge summary for each patient referred to be requested by the center.

(c) The written transfer agreements shall include designation of responsibility for:

1. Transfer of information;

2. Provision of transportation;

3. Sharing of services, equipment, and personnel;

4. Provision of total care or portions thereof in relation to center and agency capability; and

5. Patient record confidentiality pursuant to all applicable federal and state law.

(d) A linkage agreement shall not be required to transfer health records to any other treating health care facility or provider.

(7) Quality assurance program. The center shall have an ongoing, written quality assurance program established in accordance with Section 5(6)(a) of this administrative regulation.

Section 8[5]. Crisis Stabilization.

(1) Emergency services provided in a crisis stabilization unit shall include the following:

(a) A mental status evaluation and physical health questionnaire of the client upon admission;

(b) A treatment planning process;

(c) Procedure for crisis intervention; and

(d) Discharge and aftercare planning processes.

(2) A program shall have a written policy concerning the operation of a crisis stabilization unit including:

(a) Staffing.

1. At least one (1) direct-care staff member shall be assigned direct-care responsibility for:

a. Every four (4) clients during normal waking hours; and

b. Every six (6) clients during normal sleeping hours;

2. Administrative oversight of the program shall be provided by a staff member who shall be:

a. A person licensed or certified to provide mental health services independent of clinical supervision;

b. A qualified mental health professional as defined in KRS 202A.011(12); or

c. A person qualified to be program director under Section 4(1)(b)[3(5)(a)] of this administrative regulation*; and*[*.*]

3. The center shall provide a training program for direct care staff pertaining to the care of a client in a crisis stabilization unit.

(b) Criteria to assure that each client in a crisis stabilization program shall be:

1. In either one (1) of two (2) separate programs, child or adult, separated by physical location. A children's program may serve a resident up to age twenty-one (21) if it is more developmentally appropriate for that resident;

2. In need of short-term behavior management and at risk of placement in a higher level of care;

3. Able to take care of his own personal needs, if an adult;

4. Medically able to participate in services; and

5. Served in the least restrictive environment available in the community.

(c) Referrals for physical health services to include diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the client's stay in the crisis stabilization unit or for problems identified during the admission assessment.

(d) Rights of a crisis stabilization client, to include:

1. A description of the client's rights and the means by which these rights are protected and exercised.

2. At the point of admission, the program shall provide the statement of rights and responsibilities to the:

a. Client; and

b. In addition to the client, client's[his] parents,[if he is a child, his] guardian, or other legal representative if the client is a minor or incapacitated[with a clearly written and readable statement of rights and responsibilities].

3. The statement shall:

a. Be written in language that is understandable;

b. Be read to the client or if the client is a minor, client's[and his] parents,[if he is a child, his] guardian, or other legal representative if requested or if either cannot read; and

c.[shall] Cover the following:

(i)[a.] The right to treatment, regardless of race, religion, or ethnicity;

(ii)[b.] The right to recognition and respect of personal dignity in the provision of all treatment and care;

(iii)[c.] The right to be provided treatment and care in the least restrictive environment possible;

(iv)[d.] The right to an individualized plan of care;

(v)[e.] The right of the client, including the client's[and his] parents or guardian if the client is a minor,[if he is a child, or his legal representative,] to participate in treatment planning;

(vi)[f.] The nature of care, procedures, and treatment provided[that he shall receive];

(vii)[g.] The right to an explanation of risks, side effects, and benefits of all medications and treatment procedures used; and

(viii)[h.] The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the client refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with the client upon reasonable notice.

4.[3.] The statement of rights and responsibilities[of clients shall be written in language which is understandable to the client, and his parents, if he is a child, his guardian or other legal representative, and] shall be posted in appropriate areas of the facility.

5.[4.] The written policies and procedures[policy and procedure] concerning client[the clients'] rights shall assure and protect the client's[client] personal privacy within the constraints of his or her plan of care, including[. These rights to privacy shall include]:

a. Visitation by family or significant others in a suitable area of the facility; and

b. Telephone communications with family or significant others at a reasonable frequency.

6.[5.] If a privacy right is limited, a full explanation shall be given to the client or the client's parent or guardian if the client is a minor[and his parents, if he is a child, or his guardian or other legal representative, shall receive a full explanation]. A limitation to a privacy right shall be documented in the client's record.

7. Information shall be provided to[6.] the client, or the client's parent or guardian if the client is a minor, regarding[and his parents, if he is a child, his guardian, or other legal representative, shall be informed of] the use and disposition of a product of special observation and audio visual techniques, which may include the following[such as]:

a. One (1) way vision mirror;

b. Audio recording;

c. Video tape recording;

d. Television;

e. Movie; or

f. Photograph.

8.a.[7.] Written policy and procedure developed in consultation with professional and direct-care staff shall provide for behavior management of a child client, including the use of a time-out room.

b.[The policy and procedure for use of a time-out room shall be approved by the Department for Mental Health and Mental Retardation.] Behavior management techniques shall be explained fully to each client and the client's parent[his parents], or[his] guardian, or other legal representative if the client is a child or otherwise incapacitated.

9.[8.] The facility shall prohibit cruel and unusual behavioral management measures, including corporal punishment, the use of a seclusion room, and mechanical restraint[as defined in 902 KAR 20:320].

10.[9.] Written policy shall prohibit a client from administering a disciplinary measure upon another client and shall prohibit a person other than professional or direct-care staff from administering a disciplinary measure to a child client.

(e) If therapeutic holds are used[The use of therapeutic holds] as a safe behavioral management technique, the facility shall have a[. The] policy that shall describe:

1. Criteria for appropriate use of therapeutic holds;

2. Documentation requirements; and

3. The requirement for completion of a training course approved by the Department for Behavioral Health, Developmental and Intellectual Disabilities[of Mental Health and Mental Retardation,] prior to using therapeutic holds.

(f) The requirement that a licensed psychiatrist shall be available to evaluate, provide treatment and participate in treatment planning on a regular basis.

(g) The procedure for proper management of pharmaceuticals, consistent with the requirements of Section *5(7)[4(6)]* of this administrative regulation.

(h) Except for a program accredited by the Joint Commission[for Accreditation of Health Organizations] or the Commission on Accreditation of Rehabilitation Facilities, general procedures that address the following:

1. Procedures to be followed by staff in the event of a medical emergency of a client;
2. Proper nutrition;
3. Emergency preparedness;
4. Security; and
5. School attendance for children.

(3) Facility requirements for a crisis stabilization unit.

(a) A living unit shall be located within a single building and shall include:

1. Bedrooms.

a. More than four (4) clients shall not sleep in a bedroom.

b. A bedroom shall be equipped with a bed for each client.

c. A bed shall:

(i) Be at least thirty-six (36) inches wide and at least five (5) feet in length;

(ii)[and shall] Be long and wide enough to accommodate the client's size;

(iii)[. d. A bed shall] Have a mattress cover, two (2) sheets, a pillow, and bed covering as is required to keep the client comfortable;

(iv)[. e. A bed shall] Be equipped with a support mechanism and a clean mattress; and

(v)[. f. A bed shall] Be placed so that a client shall not experience discomfort because of proximity to a radiator or heat outlet, or exposure to a draft.

d.[g.] There shall be separate sleeping quarters for males and females.

e.[h.] A client shall not be housed in a room, a detached building, or other enclosure that has not previously been inspected and approved for residential use by the licensure agency and the Department of Housing, Buildings and Construction.

2. Bathrooms.

a. For every eight (8) residents, each living unit shall have at least one (1):

(i) Wash basin with hot and cold water;

(ii)[, one (1)] Flush toilet;[,] and

(iii)[one (1)] Bath or shower with hot and cold water[for every eight (8) resident clients].

b. If separate toilet and bathing facilities are not provided, males and females shall not be permitted to use those facilities at the same time.

3. Living area.

a. The living area shall provide comfortable seating for all clients housed within the living unit.

b. Each living unit shall be equipped with a:

(i) Working sink; and

(ii)[,] Stove and refrigerator, unless a kitchen is directly available within the same building as the living unit.

c. A living unit shall house a maximum of sixteen (16)[twelve (12)] clients.

Section 9[6]. Facility Specifications.

(1) A facility housing a community mental health center or a crisis stabilization unit shall be a general purpose building of safe and substantial construction and shall be in compliance with applicable state

and local laws relating to zoning, construction, plumbing, safety, and sanitation. The following shall apply if relevant and as adopted by the respective agency authority:

(a) Requirements for fire safety pursuant to 815 KAR 10:060; and

(b) Requirements for making a building or facility accessible to and usable by an individual with disabilities, pursuant to KRS 198B.260 and administrative regulations promulgated thereunder.

(2) Prior to occupancy, the facility shall have final approval from appropriate agencies.

(3) A facility shall be currently approved by the Department of Housing, Buildings and Construction in accordance with 815 KAR 10:060, before relicensure is granted by the licensure agency.

ROBERT S. SILVERTHORN, JR., Inspector General
VICKIE YATES BROWN GLISSON, Secretary
APPROVED BY AGENCY: October 28, 2016
FILED WITH LRC: November 1, 2016 at 10 a.m.
CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

Cabinet for Health and Family Services - 902 KAR 20:440. Facilities specifications, operation and services; residential crisis stabilization units. www.lrc.ky.gov/kar/902/020/440.htm

RELATES TO: KRS 200.503(2), 210.005, 309.130(2), 311.571, 311.840 – 311.862, 314.042, 319.050, 319.056, 319C.010, 335.080, 335.100, 335.300, 335.500, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d-2 – 1320d-8, 42 U.S.C. 209ee-3, 42 C.F.R. Part 2

STATUTORY AUTHORITY: KRS 216B.042

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042 requires the Cabinet for Health and Family Services to promulgate administrative regulations necessary for the proper administration of the licensure function, which includes establishing licensure standards and procedures to ensure safe, adequate, and efficient health facilities and health services. This administrative regulation establishes minimum licensure requirements for the operation of residential crisis stabilization units which serve at-risk children or children with severe emotional disabilities, at-risk adults or adults with severe mental illness, or individuals with substance use disorder or co-occurring disorders.

Section 1. Definitions.

(1) "Behavioral health professional" means:

(a) A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc;

(b) A physician licensed in Kentucky to practice medicine or osteopathy in accordance with KRS 311.571;

(c) A psychologist licensed and practicing in accordance with KRS 319.050;

(d) A certified psychologist with autonomous functioning or licensed psychological practitioner practicing in accordance with KRS 319.056;
(e) A clinical social worker licensed and practicing in accordance with KRS 335.100;
(f) An advanced practice registered nurse licensed and practicing in accordance with KRS 314.042;
(g) A physician assistant licensed under KRS 311.840 to 311.862;
(h) A marriage and family therapist licensed and practicing in accordance with KRS 335.300;
(i) A professional clinical counselor licensed and practicing in accordance with KRS 335.500; or
(j) A licensed professional art therapist as defined by KRS 309.130(2).

(2) "Behavioral health professional under clinical supervision" means a:
(a) Psychologist certified and practicing in accordance with KRS 319.056;
(b) Licensed psychological associate licensed and practicing in accordance with KRS 319.064;
(c) Marriage and family therapist associate as defined by KRS 335.300(3);
(d) Social worker certified and practicing in accordance with KRS 335.080;
(e) Licensed professional counselor associate as defined by KRS 335.500(4); or
(f) Licensed professional art therapist associate as defined by KRS 309.130(3).

(3) "Cabinet" means the Cabinet for Health and Family Services.

(4) "Certified alcohol and drug counselor" is defined by KRS 309.080(2).

(5) "Chemical restraint" means the use of a drug that:
(a) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
(b) Has the temporary effect of restricting the resident's freedom of movement; and
(c) Is not a standard treatment for the resident's medical or psychiatric condition.

(6) "Child with a severe emotional disability" is defined by KRS 200.503(3).

(7) "Crisis stabilization unit" means a community-based facility that is not part of an inpatient unit and which provides crisis services to no more than twelve (12) clients who require overnight stays.

(8) "Mechanical restraint" means any device attached or adjacent to a resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

(9) "Peer support specialist" means a paraprofessional who:
(a) Meets the application, training, examination, and supervision requirements of 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240; and
(b) Works under the supervision of one (1) of the following:
1. Physician;
2. Psychiatrist;
3. Licensed psychologist;
4. Licensed psychological practitioner;
5. Licensed psychological associate;
6. Licensed clinical social worker;
7. Licensed marriage and family therapist;
8. Licensed professional clinical counselor;
9. Certified social worker;
10. Licensed marriage and family therapist associate;
11. Licensed professional counselor associate;

12. Licensed professional art therapist;
13. Licensed professional art therapist associate;
14. Advanced practice registered nurse;
15. Physician assistant; or
16. Certified alcohol and drug counselor.

(10) "Personal restraint" means the application of physical force without the use of any device for the purpose of restraining the free movement of a resident's body and does not include briefly holding without undue force a resident in order to calm or comfort him or her or holding a resident's hand to safely escort him or her from one (1) area to another.

(11) "Seclusion" means the involuntary confinement of a resident alone in a room or in an area from which the resident is physically prevented from leaving.

(12) "Severe mental illness" means the conditions defined by KRS 210.005(2) and (3).

(13) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms resulting from use of a substance which the individual continues to take despite experiencing substance-related problems as a result, including:
   (a) Intoxication;
   (b) Withdrawal; or
   (c) A substance induced mental health disorder.

(14) "Time out" means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Section 2. Licensure Application and Fees.

(1) An applicant for initial licensure as a residential crisis stabilization unit shall submit to the Office of Inspector General:
   (a) A completed Application for License to Operate a Residential Crisis Stabilization Unit; and
   (b) An accompanying initial licensure fee in the amount of $750, made payable to the Kentucky State Treasurer.

(2) At least sixty (60) calendar days prior to the date of annual renewal, a residential crisis stabilization unit shall submit to the Office of Inspector General:
   (a) A completed Application for License to Operate a Residential Crisis Stabilization Unit; and
   (b) An annual renewal fee of $500, made payable to the Kentucky State Treasurer.

(3) (a) Name change. A residential crisis stabilization unit shall:
      1. Notify the Office of Inspector General in writing within ten (10) calendar days of the effective date of a change in the unit's name; and
      2. Submit a processing fee of twenty-five (25) dollars.
   (b) Change of location. A residential crisis stabilization unit shall not change the location where the unit is operated until an Application for License to Operate a Residential Crisis Stabilization Unit accompanied by a fee of $100 is filed with the Office of Inspector General.
   (c) Change of ownership.
      1. The new owner of a residential crisis stabilization unit shall submit to the Office of Inspector General an Application for License to Operate a Residential Crisis Stabilization

Unit accompanied by a fee of $750 within ten (10) calendar days of the effective date of the ownership change.

2. A change of ownership for a license shall be deemed to occur if more than twenty-five (25) percent of an existing residential crisis stabilization unit or capital stock or voting rights of a corporation is purchased, leased, or otherwise acquired by one (1) person from another.

(4) To obtain approval of initial licensure or renew a license to operate a residential crisis stabilization unit, the licensee shall be in compliance with this administrative regulation and federal, state, and local laws and regulations pertaining to the operation of the unit.

Section 3. Location.

If an alcohol and other drug abuse treatment program licensed pursuant to 908 KAR 1:370 obtains separate licensure under this administrative regulation to operate a residential crisis stabilization unit, the unit shall be located off the campus of any residential treatment program licensed pursuant to 908 KAR 1:370.

Section 4. Accreditation.

(1) Unless an extension is granted pursuant to subsection (2) of this section, an entity licensed under this administrative regulation to operate a residential crisis stabilization unit shall become accredited within one (1) year of initial licensure by one (1) of the following:
   (a) Joint Commission;
   (b) Commission on Accreditation of Rehabilitation Facilities;
   (c) Council on Accreditation; or
   (d) A nationally recognized accreditation organization.

(2) (a) If a residential crisis stabilization unit has not obtained accreditation in accordance with subsection (1) of this section within one (1) year of initial licensure, the facility may request a one (1) time only extension to complete the accreditation process.
   (b) A request for extension shall:
      1. Be submitted in writing to the Office of Inspector General at least sixty (60) days prior to the date of annual renewal;
      2. Include evidence that the facility initiated the process of becoming accredited within sixty (60) days of initial licensure and is continuing its efforts to obtain accreditation; and
      3. Include an estimated timeframe by which approval of accreditation is anticipated.

(3) The cabinet shall revoke the license if the residential crisis stabilization unit fails to meet one (1) of the following requirements:
   (a) Become accredited in accordance with subsection (1) of this section;
   (b) Request an extension in accordance with subsection (2) of this section if accreditation has not been obtained within one (1) year of initial licensure; or
   (c) Maintain accreditation.

(4) Proof of accreditation shall be provided to the Office of Inspector General upon receiving accreditation within one (1) year of initial licensure and at the time of annual renewal described in Section 2(2) of this administrative regulation.

Section 5. Administration and Operation.

(1) The licensee shall be legally responsible for:
   (a) The residential crisis stabilization unit;
   (b) The establishment of administrative policy; and
   (c) Ensuring compliance with federal, state, and local laws and regulations pertaining to the operation of the residential crisis stabilization unit.

(2) Executive director. The licensee shall establish lines of authority and designate an executive director who:
   (a) May serve in a dual role as the residential crisis stabilization unit's program director described in subsection (5) of this section;
   (b) May serve in a dual role as the executive director of a behavioral health services organization (BHSO) if:
      1. The residential crisis stabilization unit and the BHSO are owned by the same entity; and
      2. The residential crisis stabilization unit has a linkage with the BHSO to assist with continuity of care if needed after discharge from the crisis stabilization unit;
   (c) Shall be responsible for the administrative management of the residential crisis stabilization unit, including:
      1. The total program of the unit in accordance with the unit's written policies; and
      2. Evaluation of the unit as it relates to the needs of each resident; and
   (d) Shall have a master's degree in business administration or a human services field, or a bachelor's degree in a human services field, including:
      1. Social work;
      2. Sociology;
      3. Psychology;
      4. Guidance and counseling;
      5. Education;
      6. Religion;
      7. Business administration;
      8. Criminal justice;
      9. Public administration;
      10. Child care administration;
      11. Christian education;
      12. Divinity;
      13. Pastoral counseling;
      14. Nursing;
      15. Public health; or
      16. Another human service field related to working with children with severe emotional disabilities or clients with severe mental illness.

(3) An executive director with a master's degree shall have a minimum of two (2) years of prior supervisory experience in a human services program.

(4) An executive director with a bachelor's degree shall have a minimum of two (2) years of prior experience in a human services program plus two (2) years of prior supervisory experience in a human services program.

(5) A residential crisis stabilization unit shall have a program director who:
  (a) May serve in a dual role as the program director of a BHSO if:
    1. The residential crisis stabilization unit and the BHSO are owned by the same entity; and
    2. The residential crisis stabilization unit has a linkage with the BHSO to assist with continuity of care if needed after discharge from the crisis stabilization unit; and
  (b) Shall be a:
    1. Psychiatrist;
    2. Physician;
    3. Certified or licensed psychologist;
    4. Licensed psychological practitioner;
    5. Advanced practice registered nurse;
    6. Licensed professional clinical counselor;
    7. Licensed marriage and family therapist;
    8. Licensed professional art therapist;
    9. Licensed board certified behavior analyst; or
    10. Licensed clinical social worker.

Section 6. License Procedures.
An entity licensed under this administrative regulation to operate a residential crisis stabilization unit shall be subject to the provisions of 902 KAR 20:008, Sections 1, 2, 5, 6, and 7.

Section 7. Background Checks and Personnel Records.
(1) All personnel of a residential crisis stabilization unit shall:
  (a) Have a criminal record check performed upon initial hire and every two (2) years through the Administrative Office of the Courts or the Kentucky State Police;
  (b) Not have a criminal conviction, or plea of guilty, to a:
    1. Sex crime as specified in KRS 17.500;
    2. Violent crime as specified in KRS 439.3401;
    3. Criminal offense against a minor as specified in KRS 17.500; or
    4. Class A felony; and
  (c) Not be listed on the following:
    1. Central registry established by 922 KAR 1:470;
    2. Nurse aide or home health aide abuse registry established by 906 KAR 1:100; or
    3. Caregiver misconduct registry established by 922 KAR 5:120E and 922 KAR 5:120.
(2) (a) Prior to initial hire, an out-of-state criminal background information check shall be obtained for any applicant recommended for employment in a residential crisis stabilization unit who has resided or resides outside of the Commonwealth.
  (b) A residential crisis stabilization unit may use Kentucky's national background check system established by 906 KAR 1:190 to satisfy the background check requirements of subsections (1) and (2)(a) of this section.
(3) A residential crisis stabilization unit shall perform annual criminal record and registry checks as described in subsection (1) of this section on a random sample of at least twenty-five (25) percent of all personnel.

(4) A personnel record shall be kept on each staff member and shall contain the following items:
   (a) Name and address;
   (b) Verification of all training and experience, including licensure, certification, registration, or renewals;
   (c) Verification of submission to the background check requirements of subsections (1), (2), and (3) of this section;
   (d) Performance appraisals conducted no less than annually; and
   (e) Employee incident reports.

Section 8. Quality Assurance and Utilization Review.

(1) The residential crisis stabilization unit shall have a quality assurance and utilization review program designed to:
   (a) Enhance treatment and care through the ongoing objective assessment of services provided, including the correction of identified problems; and
   (b) Provide an effective mechanism for review and evaluation of the service needs of each client.
(2) The need for continuing services shall be evaluated immediately upon a change in a client's service needs or a change in the client's condition to ensure that proper arrangements have been made for:
   (a) Discharge;
   (b) Transfer; or
   (c) Referral to another service provider, if appropriate.

Section 9. Client Grievance Policy.

The residential crisis stabilization unit shall have written policies and procedures governing client grievances which shall include the following:

(1) A process for filing a written client grievance;
(2) An appeals process with time frames for filing and responding to a grievance in writing;
(3) Protection for a client from interference, coercion, discrimination, or reprisal; and
(4) Conspicuous posting of the grievance procedures in a public area to inform a client of:
   (a) His or her right to file a grievance;
   (b) The process for filing a grievance; and
   (c) The address and telephone number of the cabinet's ombudsman.

Section 10. Services and Staffing.

(1) An entity licensed under this administrative regulation to operate a residential crisis stabilization unit shall provide the following services:
   (a) Screening;
   (b) Assessment;
   (c) Treatment planning;
   (d) Individual outpatient therapy;
   (e) Group outpatient therapy; and
   (f) Psychiatric services.

(2) An entity licensed under this administrative regulation to operate a residential crisis stabilization unit may provide:
  (a) Family therapy; or
  (b) Peer support by a peer support specialist.

(3) (a) Except as provided by paragraph (b) of this subsection, the services identified in subsection (1) and (2)(a) of this section shall be delivered by a behavioral health professional or a behavioral health professional under clinical supervision.
  (b) In addition to the professionals identified in paragraph (a) of this subsection, the services identified in subsection (1)(a), (b), (d), and (e) and subsection (2)(a) of this section may be provided by a certified alcohol and drug counselor.
  (c) 1. A residential crisis stabilization unit shall have access to a board-certified or board-eligible psychiatrist twenty-four (24) hours per day, seven (7) days per week.
    2. The psychiatrist may serve more than one (1) residential crisis stabilization unit and be available through telehealth consultation.
  (d) The psychiatrist shall be available to evaluate, provide treatment, and participate in treatment planning.

(4) If a crisis stabilization program serves adults with a severe mental illness or substance use disorder and children with severe emotional disabilities:
  (a) The programs shall not be located on the same campus; and
  (b) The children's program shall serve clients:
    1. Under the age of eighteen (18); or
    2. Up to the age of twenty-one (21) if developmentally appropriate for the client.

(5) A residential crisis stabilization unit shall:
  (a) Provide treatment for acute withdrawal, if appropriate;
  (b) Complete a mental status evaluation and physical health questionnaire of the client upon admission;
  (c) Have written policies and procedures for:
    1. Crisis intervention; and
    2. Discharge planning which shall begin at the time of admission and aftercare planning processes;
  (d) Make referrals for physical health services to include diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the client's stay in the residential crisis stabilization unit or identified during the admission assessment;
  (e) Have a description of linkages with behavioral health services organizations licensed under 902 KAR 20:430 or other programs which:
    1. Address identified needs and achieve goals specified in the treatment plan; and
    2. Help promote continuity of care after discharge;
  (f) Have at least one (1) direct-care staff member assigned direct-care responsibility for:
    1. Every four (4) clients during normal waking hours; and
    2. Every six (6) clients during normal sleeping hours;
  (g) Ensure that administrative management of the unit is provided by the unit's executive director;
  (h) Provide a training program for direct-care staff pertaining to:

1. The care of clients in a crisis stabilization unit;
2. Detection and reporting of abuse, neglect, or exploitation;
3. Emergency and safety procedures;
4. Behavior management, including de-escalation training;
5. Physical management procedures and techniques;
6. Suicide prevention and care; and
7. Trauma informed care; and

(i) Assure that each client shall be:

1. In need of short-term behavior management and at risk of placement in a higher level of care;
2. Able to take care of his or her own personal needs, if an adult;
3. Medically able to participate in services; and
4. Served in the least restrictive environment available in the community.

Section 11. Client Records.

(1) A client record shall be maintained for each individual receiving services.
(2) Each entry shall be current, dated, signed, and indexed according to the service received.
(3) Each client record shall contain:
   (a) An identification sheet, including the client's name, address, date of birth, gender, marital status, expected source of payment, and referral source;
   (b) Information on the purpose for seeking a service;
   (c) If applicable, consent via signature of appropriate family members or guardians for admission, evaluation, and treatment;
   (d) Mental status evaluation and physical health questionnaire of the client taken upon admission;
   (e) Staff notes for all services provided;
   (f) Documentation of treatment planning, including diagnosis and all services to be provided; and
   (g) Documentation of medication prescribing and monitoring used in treatment.
(4) Ownership.
   (a) Client records shall be the property of the residential crisis stabilization unit.
   (b) The original client record shall not be removed from the unit except by court order or subpoena.
   (c) Copies of a client record or portions of the record may be used and disclosed. Use and disclosure shall be as established by subsection (6) of this section.
(5) Retention of records. After a client's death or discharge, the completed client record shall be placed in an inactive file and:
   (a) Retained for six (6) years; or
   (b) If a minor, three (3) years after the client reaches the age of majority under state law, whichever is the longest.
(6) Confidentiality and Security: Use and Disclosure.
   (a) The residential crisis stabilization unit shall maintain the confidentiality and security of client records in compliance with the Health Insurance Portability and Accountability Act of 1996

(HIPAA), 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164, as amended, including the security requirements mandated by subparts A and C of 45 C.F.R. Part 164, or as provided by applicable federal or state law, including 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

(b) The residential crisis stabilization unit may use and disclose client records. Use and disclosure shall be as established or required by:
   1. HIPAA, 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164; or
   2. 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

(c) A residential crisis stabilization unit may establish higher levels of confidentiality and security than required by HIPAA, 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164, or 42 U.S.C. 290ee-3, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

Section 12. Client Rights.

(1) A residential crisis stabilization unit shall have written policies and procedures to ensure that the rights of a client are protected, including a statement of rights and responsibilities which shall be:
   (a) Provided at the time of admission:
      1. To the client; or
      2. If the client is a minor or incapacitated, to the client, client's parent, guardian, or other legal representative;
   (b) Read to the client or client's parent, guardian, or other legal representative if requested or if either cannot read;
   (c) Written in language that is understandable to the client;
   (d) Conspicuously posted in a public area of the facility; and
   (e) Cover the following:
      1. The right to treatment, regardless of race, religion, or ethnicity;
      2. The right to recognition and respect of personal dignity in the provision of all treatment and care;
      3. The right to be provided treatment and care in the least restrictive environment possible;
      4. The right to an individualized plan of care;
      5. The right of the client, including the client's parents or guardian if the client is a minor, to participate in treatment planning;
      6. The nature of care, procedures, and treatment provided;
      7. The right to an explanation of risks, side effects, and benefits of all medications and treatment procedures used;
      8. The right to be free from verbal, sexual, physical, or mental abuse; and
      9. The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the client refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or in accordance with professional standards, to terminate the relationship with the client upon reasonable notice.

(2) A residential crisis stabilization unit's written policies and procedures concerning client rights shall assure and protect the client's personal privacy within the constraints of his or her plan of care, including:
  (a) Visitation by family or significant others in a suitable area of the facility; and
  (b) Telephone communications with family or significant others at a reasonable frequency.
(3) (a) If a privacy right is limited, a full explanation shall be given to the client or the client's parent or guardian if the client is a minor.
  (b) Documentation shall be included in the client's record of any privacy limitation.
(4) Information shall be provided to the client, or the client's parent or guardian if the client is a minor, regarding the use and disposition of special observation and audio visual techniques, which may include the following:
  (a) One (1) way vision mirror;
  (b) Audio recording;
  (c) Video tape recording;
  (d) Television;
  (e) Movie; or
  (f) Photographs.
(5) (a) If the residential crisis stabilization unit serves children as described in Section 10(4)(b) of this administrative regulation, written policy and procedures shall be developed in consultation with professional and direct-care staff to provide for behavior management of residents, including the use of a time-out room.
  (b) 1. Behavior management techniques:
    a. Shall be explained fully to each client and the client's parent, guardian, or other legal representative; and
    b. May include time out or personal restraint.
  2. Prone holds, chemical restraint, and mechanical restraint shall be prohibited in a residential crisis stabilization unit.
  (c) The unit shall prohibit cruel and unusual disciplinary measures including the following:
    1. Corporal punishment;
    2. Forced physical exercise;
    3. Forced fixed body positions;
    4. Group punishment for individual actions;
    5. Verbal abuse, ridicule, or humiliation;
    6. Denial of three (3) balanced nutritional meals per day;
    7. Denial of clothing, shelter, bedding, or personal hygiene needs;
    8. Denial of access to educational services;
    9. Denial of visitation, mail, or phone privileges for punishment;
    10. Exclusion of the resident from entry to his or her assigned living unit; and
    11. Personal restraint or seclusion as a punishment or employed for the convenience of staff.
  (d) Written policy shall prohibit residents from administering disciplinary measures upon one another and shall prohibit persons other than professional or direct-care staff from administering disciplinary measures to residents.

(6) If personal restraint is used as a safe behavioral management technique, the residential crisis stabilization unit shall have a policy which shall:
  (a) Describe criteria for appropriate use of personal restraint;
  (b) Describe documentation requirements; and
  (c) Ensure that staff who implement the use of personal restraint shall:
    1. Have documented training in the proper use of the procedure used;
    2. Be certified in physical management by a nationally-recognized training program in which certification is obtained through skilled-out testing; and
    3. Receive annual training and recertification in crisis intervention and behavior management.

Section 13. Reports of Abuse, Neglect, or Exploitation.

(1) A residential crisis stabilization unit shall have written policies which assure:
  (a) The reporting of cases of abuse, neglect, or exploitation of adults and children to the cabinet pursuant to KRS Chapters 209 and 620; and
  (b) That a resident may file a complaint with the cabinet concerning resident abuse, neglect, or exploitation.
(2) The unit shall have evidence that all allegations of abuse, neglect, or exploitation are thoroughly investigated internally, and shall prevent further potential abuse while the investigation is in progress.

Section 14. Medication Prescribing and Monitoring in a Residential Crisis Stabilization Unit.

(1) Medication prescribing and monitoring shall be under the direction of a licensed psychiatrist, a licensed physician supervised by a psychiatrist, or an APRN certified in psychiatric-mental health nursing practice who meets the requirements established in 201 KAR 20:057.
(2) Prescriptions concerning medication shall not exceed an order for more than five (5) refills.
(3) Medication prescribing and monitoring used in treatment shall be recorded in the staff notes and on a special medications chart in the client record.
(4) A copy of the prescription shall be kept in the client record.
(5) A blood or other laboratory test or examination shall be performed in accordance with accepted medical practice on each client receiving medication prescribed or administered by the residential crisis stabilization unit staff.
(6) Drug supplies shall be stored under proper sanitary, temperature, light, and moisture conditions.
(7) Medication kept by the unit shall be properly labeled.
(8) A medication shall be stored in the originally received container unless transferred to another container by a pharmacist or another person licensed to transfer the medication.
(9) Medication kept in the unit shall be kept in a locked cabinet.
(10) A controlled substance shall be kept under double lock (for example, in a locked box in a locked cabinet).
(11) There shall be a controlled substances record, in which is recorded:
  (a) The name of the client;
  (b) The date, time, dosage, balance remaining, and method of administration of each controlled substance;

(c) The name of the prescribing physician or other ordering practitioner acting within the scope of his or her license to practice; and
(d) The name of the nurse who administered it, or staff who supervised the self-administration.

(12) Access to the locked cabinet shall be restricted to a designated medication nurse or other authorized personnel.

(13) Medication to be self-administered shall be made available to the client at the time of administration.

Section 15. Facility Requirements.

(1) Living Unit. A living unit shall be located within a single building in which there is at least 120 square feet of space for each resident in the facility.

(2) Bedrooms.
(a) More than four (4) clients shall not sleep in a bedroom.
(b) A bedroom shall be equipped with a bed for each client.
(c) A bed shall:
1. Be at least thirty-six (36) inches wide and at least five (5) feet in length;
2. Be long and wide enough to accommodate the client's size;
3. Have a mattress cover, two (2) sheets, a pillow, and bed covering to keep the client comfortable;
4. Be equipped with a support mechanism and a clean mattress; and
5. Be placed so that a client shall not experience discomfort because of proximity to a radiator or heat outlet, or exposure to a draft.
(d) There shall be separate sleeping quarters for males and females.
(e) A client shall not be housed in a room, a detached building, or other enclosure that has not previously been inspected and approved for residential use by the Office of Inspector General and the Department of Housing, Buildings and Construction.

(3) Bathrooms.
(a) For every eight (8) residents, each residential crisis stabilization unit shall have at least one (1):
1. Wash basin with hot and cold water;
2. Bath or shower with hot and cold water; and
3. Flush toilet.
(b) If separate toilet and bathing facilities are not provided, males and females shall not be permitted to use those facilities at the same time.

(4) Living area.
(a) The living area shall provide comfortable seating for all clients housed within the residential crisis stabilization unit.
(b) Each living unit shall be equipped with a:
1. Working sink; and
2. Stove and refrigerator, unless a kitchen is directly available within the same building as the living unit.

(5) There shall be adequate lighting, heating, heated water, and ventilation.

(6) There shall be space for a client to store personal belongings, including a receptacle where personal property may be stored and locked.
(7) The residential crisis stabilization unit shall be kept in good repair, neat, clean, free from accumulations of dirt and rubbish, and free from foul, stale, and musty odors.
(8) The residential crisis stabilization unit shall be kept free from insects and rodents with their harborages eliminated.
(9) The residential crisis stabilization unit shall establish an infection control system which includes training personnel on proper hygiene related to infections prevalent among alcohol and other drug abusers.
(10) Services shall be provided in an area where clients are ensured privacy and confidentiality.

Section 16. Facility Specifications.

(1) A residential crisis stabilization unit shall:
    (a) Be of safe and substantial construction;
    (b) Be in compliance with applicable state and local laws relating to zoning, construction, plumbing, safety, and sanitation;
    (c) Be approved by the State Fire Marshal's office prior to initial licensure or if the unit changes location; and
    (d) Meet requirements for making buildings and facilities accessible to and usable by individuals with physical disabilities pursuant to KRS 198B.260 and 815 KAR 7:120.
(2) A residential crisis stabilization unit shall:
    (a) Have a written emergency plan and procedures for meeting potential disasters such as fires or severe weather;
    (b) Post the emergency plan conspicuously in a public area of the unit and provide a copy to all personnel;
    (c) Provide training for all personnel on how to report a fire, extinguish a small fire, and evacuate a building; and
    (d) Practice fire drills monthly, with a written record kept of all practiced fire drills, detailing the date, time, and residents who participated.

Section 17. Denial and Revocation.

(1) The cabinet shall deny an Application for License to Operate a Residential Crisis Stabilization Unit if:
    (a) Any person with ownership interest in the crisis stabilization unit has had previous ownership interest in a health care facility that had its license revoked or voluntarily relinquished its license as the result of an investigation or pending disciplinary action;
    (b) Any person with ownership interest in the crisis stabilization unit has been discontinued from participation in the Medicaid Program due to fraud or abuse of the program; or
    (c) The applicant fails after the initial inspection to submit an acceptable plan of correction or fails to submit an acceptable amended plan of correction within the timeframes required by 902 KAR 20:008, Section 2(5).
(2) The cabinet shall revoke a license if it finds that:

(a) In accordance with KRS 216B.105(2), there has been a substantial failure by the residential crisis stabilization unit to comply with the provisions of this administrative regulation;
(b) The residential crisis stabilization unit fails to submit an acceptable plan of correction or fails to submit an acceptable amended plan of correction within the timeframes required by 902 KAR 20:008, Section 2(5); or
(c) The residential crisis stabilization unit is terminated from participation in the Medicaid Program pursuant to 907 KAR 1:671.

(3) The denial or revocation of a residential crisis stabilization unit's license shall be mailed to the applicant or licensee, by certified mail, return receipt requested, or by personal service. Notice of the denial or revocation shall set forth the particular reasons for the action.

(4) The denial or revocation shall become final and conclusive thirty (30) days after notice is given, unless the applicant or licensee, within the thirty (30) day period, files a request in writing for a hearing with the cabinet.

(5) Urgent action to suspend a license.
(a) The cabinet shall take urgent action to suspend a residential crisis stabilization unit's license if the cabinet has probable cause to believe that the continued operation of the unit would constitute an immediate danger to the health, welfare, or safety of its residents.
(b) 1. The residential crisis stabilization unit shall be served with notice of the hearing on the urgent suspension to be held no sooner than twenty (20) days from the delivery of the notice.
2. Notice of the urgent suspension shall set forth the particular reasons for the action.

(6) Notice of a hearing on an urgent suspension shall be served on the residential crisis stabilization unit by certified mail, return receipt requested, or by personal service.

(7) (a) Within five (5) working days of completion of the hearing, the cabinet's hearing officer shall render a written decision affirming, modifying, or revoking the urgent suspension.
(b) The urgent suspension shall be affirmed if there is substantial evidence of an immediate danger to the health, safety, or welfare of the residents.

(8) The decision rendered under subsection (7) of this section shall be a final order of the agency on the matter, and any party aggrieved by the decision may appeal to circuit court.

(9) If the cabinet issues an urgent suspension, the cabinet shall take action to revoke the residential crisis stabilization unit's license pursuant to subsection (3) of this section if:
(a) The facility fails to attend the expedited hearing; or
(b) The decision rendered under subsection (7) of this section affirms that there is substantial evidence of an immediate danger to the health, safety, or welfare of the residents.

(10) Pursuant to KRS 216B.050, the cabinet may compel obedience to its lawful orders.

Section 18. Incorporation by Reference.

(1) The OIG 20:440, "Application for License to Operate a Residential Crisis Stabilization Unit", October 2014 edition, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Inspector General, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (41 Ky.R. 351; Am. 1114; eff. 1355; **eff. 12-17-2014**.)

Cabinet for Health and Family Services - 902 KAR 100:017. Special requirements for teletherapy licensees. www.lrc.ky.gov/kar/902/100/017.htm

RELATES TO: KRS 211.842-211.852, 211.990(4)
STATUTORY AUTHORITY: KRS 194.050, 211.090, 211.844
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Human Resources is empowered by KRS 211.844 to provide by regulation for the registration and licensing of the possession or use of any source of ionizing or electronic product radiation and to regulate the handling and disposal of radioactive waste. The purpose of this administrative regulation is to specify special requirements for teletherapy licensees.

Section 1. Applicability
This administrative regulation establishes special requirements for all teletherapy licensees.

Section 2. Use of a Sealed Source in a Teletherapy Unit.
A licensee shall use cobalt-60 or cesium-137 as a sealed source in a teletherapy unit for medical use only:
(1) In accordance with the manufacturer's radiation safety and operating instructions.
(2) Teletherapy sources manufactured and distributed in accordance with a license issued by the cabinet, the U.S. Nuclear Regulatory Commission or another agreement state.

Section 3. Maintenance and Repair Restrictions.
Only a person specifically licensed by the cabinet, the U.S. Nuclear Regulatory Commission, or an agreement state to perform teletherapy unit maintenance and repair shall install, relocate, or remove a teletherapy sealed source or a teletherapy unit that contains a sealed source or maintain, adjust, or repair the source drawer, the shutter or other mechanism of a teletherapy unit that could expose the source, reduce the shielding around the source, or result in increased radiation levels.

Section 4. Amendments.
In addition to the requirements specified in 902 KAR 100:073, Section 3, a licensee shall apply for and receive a license amendment before:
(1) Making any change in the treatment room shielding;
(2) Making any change in the location of the teletherapy unit within the treatment room;
(3) Using the teletherapy unit in a manner that could result in increased radiation levels in areas outside the teletherapy treatment room;
(4) Relocating the teletherapy unit; or
(5) Allowing an individual not listed on the licensee's license to perform the duties of the teletherapy physicist.

Section 5. Safety Instruction.

(1) A licensee shall post written instructions at the teletherapy unit console. These instructions shall inform the operator of:
   (a) The procedure to be followed to ensure that only the patient is in the treatment room before turning the primary beam of radiation "on" to begin a treatment or after a door interlock interruption;
   (b) The procedure to be followed if the operator is unable to turn the primary beam of radiation "off" with controls outside the treatment room or any other abnormal operation occurs; and
   (c) The names and telephone numbers of the authorized users and radiation safety officer to be immediately contacted if the teletherapy unit or console operates abnormally.
(2) A licensee shall provide instruction in the topics identified in this section to all individuals who operate a teletherapy unit and shall provide appropriate refresher training to individuals at intervals not to exceed one (1) year.
(3) A licensee shall maintain a record of individuals receiving instruction including, a description of the instruction, the date of instruction, and the name of the individual who gave the instruction for three (3) years.

Section 6. Doors, Interlocks, Warning Systems, and Survey Instruments.
(1) A licensee shall control access to the teletherapy room by a door at each entrance.
(2) A licensee shall equip each entrance to the teletherapy room with an electrical interlock system that shall:
   (a) Prevent the operator from turning the primary beam of radiation "on" unless each treatment room entrance door is closed;
   (b) Turn the beam of radiation "off" immediately when an entrance door is opened; and
   (c) Prevent the primary beam of radiation from being turned "on" following an interlock interruption until all treatment room entrance doors are closed and the beam on-off control is reset at the console.
(3) A licensee shall equip each entrance to the teletherapy room with a beam condition indicator light.
(4) A licensee authorized to use radioactive material in a teletherapy unit shall possess either a portable radiation detection survey instrument capable of detecting dose rates over the range one-tenth (0.1) millirem per hour to fifty (50) millirems per hour or a portable radiation measurement survey instrument capable of measuring dose rates over the range one (1) millirem per hour to 1000 millirems per hour. The instruments shall be operable and calibrated in accordance with 902 KAR 100:073, Section 16.

Section 7. Radiation Monitoring Device.
(1) A licensee shall have in each teletherapy room a permanent radiation monitor capable of continuously monitoring beam status.
(2) Each radiation monitor shall be capable of providing visible notice of a teletherapy unit malfunction that results in an exposed or partially exposed source. The visible indicator of high radiation levels shall be observable by an individual entering the teletherapy room.
(3) Each radiation monitor shall be equipped with a backup power supply separate from the power supply to the teletherapy unit. This backup power supply may be a battery system.

(4) A radiation monitor shall be checked with a dedicated check source for proper operation each day before the teletherapy unit is used for treatment of patients.
(5) A licensee shall maintain a record of the check required by this section for three (3) years. The record shall include the date of the check, notation that the monitor indicates when the source is exposed, and the initials of the individual who performed the check.
(6) If a radiation monitor is inoperable, the licensee shall require any individual entering the teletherapy room to use a survey instrument or audible alarm personal dosimeter to monitor for any malfunction of the source exposure mechanism that may result in an exposed or partially exposed source. The instrument or dosimeter shall be checked with a dedicated check source for proper operation at the beginning of each day of use. The licensee shall keep a record as described in this section.
(7) A licensee shall promptly repair or replace the radiation monitor if it is inoperable.

Section 8. Viewing System.
A licensee shall construct or equip each teletherapy room to permit continuous observation of the patient from the teletherapy unit console during irradiation.

Section 9. Dosimetry Equipment.
(1) A licensee shall have a calibrated dosimetry system available for use. To satisfy this requirement, one (1) of the following two (2) conditions shall be met:
  (a) The system shall have been calibrated by the National Bureau of Standards or by a calibration laboratory accredited by the American Association of Physicists in Medicine. The calibration shall have been performed within the previous two (2) years and after any servicing that may have affected system calibration; or
  (b) The system shall have been calibrated within the previous four (4) years; eighteen (18) to thirty (30) months after that calibration the system shall have been intercompared at an intercomparison meeting with another dosimetry system that was calibrated within the past twenty-four (24) months by the National Bureau of Standards or by a calibration laboratory accredited by the American Association of Physicists in Medicine. The intercomparison meeting shall be sanctioned by a calibration laboratory or radiologic physics center accredited by the American Association of Physicists in Medicine. The results of the intercomparison meeting must have indicated that the calibration factor of the licensee's system had not changed by more than two (2) percent. The licensee shall not use the intercomparison result to change the calibration factor. When intercomparing dosimetry systems to be used for calibrating cobalt-60 teletherapy units, the licensee shall use a teletherapy unit with a cobalt-60 source. When intercomparing dosimetry systems to be used for calibrating cesium-137 teletherapy units, the licensee shall use a teletherapy unit with a cesium-137 source.
(2) The licensee shall have available for use a dosimetry system for spot-check measurements. To meet this requirement, the system may be compared with a system that has been calibrated in accordance with this section. This comparison shall have been performed within the previous year and after each servicing that may have affected system calibration. The spot-check system shall be the same system used to meet the requirement in this section.

(3) The licensee shall maintain a record of each calibration, intercomparison, and comparison for the duration of the license. For each calibration, intercomparison, or comparison, the record shall include the date, the model numbers and serial numbers of the instruments that were calibrated, intercompared or compared as required by this section, the correction factors that were determined, the names of the individuals who performed the calibration, intercomparison or comparison, and evidence that the intercomparison meeting was sanctioned by a calibration laboratory or radiologic physics center accredited by the American Association of Physicists in Medicine.

Section 10. Requirements for Full Calibration Measurements of Teletherapy Units.

Any licensee authorized under these administrative regulations to use teletherapy units for treating humans shall cause full calibration measurements to be performed on each teletherapy unit:

(1) Prior to the first medical use of the unit;

(2) Prior to medical uses under the following conditions:
   (a) Whenever spot-check measurements indicate that the output value differs by more than five (5) percent from the value obtained at the last full calibration corrected mathematically for physical decay;
   (b) Following replacement of the radiation source or following reinstallation of the teletherapy unit in a new location;
   (c) Following any repair of the teletherapy unit that includes removal of the source or major repair of the components associated with the source exposure assembly; and

(3) At intervals not exceeding one (1) year.

(4) Full calibration measurements required by this section shall include determination of:
   (a) The output to an accuracy within plus or minus three (3) percent for the range of field sizes and for the distance or range of distances used for medical use;
   (b) The congruence between the radiation field and the field indicated by the light beam localizing device;
   (c) The uniformity of the radiation field and its dependence upon the orientation of the useful beam;
   (d) Timer constancy and linearity over the range of use;
   (e) The accuracy of all distance measuring devices used for medical use; and
   (f) "On-off" error.

(5) A licensee shall use the dosimetry system described in Section 9 of this administrative regulation to measure the output for one (1) set of exposure conditions. The remaining radiation measurements required in this section may then be made using a dosimetry system that indicates relative dose rates.

(6) Full calibration measurements shall be made in accordance with either the procedures recommended by the Scientific Committee on Radiation Dosimetry of the American Association of Physicists in Medicine, "Physics in Medicine and Biology," Volume 16, No. 3, 1971, pp. 379-396, filed herein by reference, or by task group 21 of the Radiation Therapy Committee of the American Association of Physicists in Medicine that are described in Medical Physics Volume 10, No. 6, 1983, pp. 741-771 and Volume 11, No. 2, 1984, p. 213, filed herein by reference.

(7) The output values determined in this section shall be corrected mathematically for physical decay for intervals not exceeding one (1) month for cobalt-60 and intervals not exceeding six (6) months for cesium-137.

(8) Full calibration measurements and physical decay corrections required by this section shall be performed by a teletherapy physicist qualified by training and experience in accordance with Section 17 of this administrative regulation and named on the licensee's license.

(9) A licensee shall maintain a record of each calibration for the duration of the license. The record shall include the date of the calibration, the manufacturer's name, model number, and serial number for both the teletherapy unit and the source, the model numbers and serial numbers of the instruments used to calibrate the teletherapy unit, tables that describe the output of the unit over the range of field sizes and for the range of distances used in radiation therapy, a determination of the coincidence of the radiation field and the field indicated by the light beam localizing device, the timer constancy and linearity for a typical treatment time, the calculated "on-off" error, the estimated accuracy of each distance measuring or localization device, and the signature of the teletherapy physicist.

Section 11. Periodic Spot-checks.

(1) Any licensee authorized to use teletherapy units for medical use shall perform output spot-check measurements on each teletherapy unit at intervals not exceeding one (1) month.

(2) Spot-check measurements shall include determination of:
   (a) Timer constancy and timer linearity over the range of use;
   (b) "On-off" error;
   (c) The congruence between the radiation field and the field indicated by the light beam localizing device;
   (d) The accuracy of all distance measuring devices and localization devices used for medical use;
   (e) The output for one (1) typical set of operating conditions; and
   (f) The difference between the measurement made in this section and the anticipated output, expressed as a percentage of the anticipated output expressed as a percentage of the anticipated output which is the value obtained at last full calibration corrected mathematically for physical decay.

(3) Spot-check measurements shall be performed in accordance with procedures established by a teletherapy physicist qualified by training and experience in accordance with Section 16 of this administrative regulation. That individual need not actually perform the spot-check measurements.

(4) A licensee shall have the teletherapy physicist review the results of each output spot-check within fifteen (15) days. The teletherapy physicist shall promptly notify the licensee in writing of the results of each output spot-check. The licensee shall keep a copy of each written notification for three (3) years.

(5) A licensee shall use the dosimetry system described in Section 9 of this administrative regulation to make the output spot-check required in this section.

(6) A licensee authorized to use a teletherapy unit for medical use shall perform safety spot-checks of each teletherapy facility at intervals not to exceed one (1) month.

(7) To satisfy the requirement of this section, safety spot- checks shall assure proper operation of:

(a) Electrical interlocks at each teletherapy room entrance;
(b) Electrical or mechanical stops installed for the purpose of limiting use of the primary beam of radiation restriction of source housing angulation or elevation, carriage or stand travel, and operation of the beam "on-off" mechanism;
(c) Beam condition indicator lights on the teletherapy unit, on the control console, and in the facility;
(d) Viewing systems;
(e) Treatment room doors from inside and outside the treatment room; and
(f) Electrically assisted treatment room doors with the teletherapy unit electrical power turned "off".

(8) A licensee shall lock the control console in the "off" position if any door interlock malfunctions. No licensee shall use the unit until the interlock system is repaired unless specifically authorized by the cabinet.

(9) A licensee shall promptly repair any system identified during safety spot-checks that is not operating properly.

(10) A licensee shall maintain a record of each spot-check required by this section for three (3) years. The record shall include the date of the spot-check, the manufacturer's name, model number, and serial number for both the teletherapy unit and source, the manufacturer's name, model number and serial number of the instrument used to measure the output of the teletherapy unit, the measured timer accuracy, the calculated "on-off" error, a determination of the coincidence of the radiation field and the field indicated by the light beam localizing device, the measured timer accuracy for a typical treatment time, the calculated "on-off" error, the estimated accuracy of each distance measuring or localization device, the difference between the anticipated output and the measured output, notations indicating the operability of each entrance door electrical interlock, each electrical or mechanical stop, each beam condition indicator light, the viewing system and doors, and the signature of the individual who performed the periodic spot-check.

Section 12. Radiation Surveys for Teletherapy Facilities.

(1) Before medical use, after each installation of a teletherapy source and after making any change for which an amendment is required by Section 4 of this administrative regulation, the licensee shall perform radiation surveys with an operable radiation measurement survey instrument calibrated in accordance with 902 KAR 100:073, Section 16 to verify that:
(a) The maximum and average radiation levels at one (1) meter from the teletherapy source with the source in the "off" position and the collimators set for a normal treatment field do not exceed ten (10) millirems per hour and two (2) millirems per hour, respectively; and
(b) With the teletherapy source in the "on" position with the largest clinically available treatment field and with a scattering phantom in the primary beam of radiation, that:
1. Radiation levels in restricted areas are not likely to cause personnel exposures in excess of the limits specified in 902 KAR 100:020, Section 2 of this administrative regulations; and
2. Radiation levels in unrestricted areas do not exceed the limits specified in 902 KAR 100:020, Section 7(1) of these administrative regulations.

(2) If the results of the surveys required in this section indicate any radiation levels in excess of the respective limit specified in that paragraph, the licensee shall lock the control in the "off" position and not use the unit:
   (a) Except as may be necessary to repair, replace, or test the teletherapy unit, the teletherapy unit shielding, or the treatment room shielding; or
   (b) Until the licensee has received a specific exemption from the cabinet.

(3) A licensee shall maintain a record of the radiation measurements made following installation of a source for the duration of the license. The record shall include the date of the measurements, the reason the survey is required, the manufacturer's name, model number and serial number of the teletherapy unit and the source, and the instrument used to measure radiation levels, each dose rate measured around the teletherapy source while in the "off" position and the average of all measurements, a plan of the areas surrounding the treatment room that were surveyed, the measured dose rate at several points in each area expressed in millirems per hour, the calculated maximum level of radiation over a period of one (1) week for each restricted and unrestricted area, and the signature of the radiation safety officer.

Section 13. Safety Spot-checks for Teletherapy Facilities.

(1) A licensee shall promptly spot-check all systems listed in Section 11(7) of this administrative regulation for proper function after each installation of a teletherapy source and after making any change for which an amendment is required by Section 4 of this administrative regulation.

(2) If the results of the spot-checks required in this section indicate the malfunction of any system specified in Section 11 of this administrative regulation, the licensee shall lock the control console in the "off" position and not use the unit except as may be necessary to repair, replace, or check the malfunctioning system.

(3) A licensee shall maintain a record of the facility checks following installation of a source for three (3) years. The record shall include notations indicating the operability of each entrance door interlock, each electrical or mechanical stop, each beam condition indicator light, the viewing system, doors, and the signature of the radiation safety officer.

Section 14. Modification of Teletherapy Unit or Room Before Beginning a Treatment Program.

If the survey required by Section 12 of this administrative regulation indicates that an individual in an unrestricted area may be exposed to levels of radiation greater than those permitted by 902 KAR 100:020, Section 7(1) of these administrative regulations before beginning the treatment program the licensee shall:

(1) Either equip the unit with stops or add additional radiation shielding to ensure compliance with 902 KAR 100:020, Section 7(1) of these administrative regulations;

(2) Perform the survey required by Section 12 of this administrative regulation again; and

(3) Include in the report required by Section 15 of this administrative regulation the results of the initial survey, a description of the modification made to comply with this section, and the results of the second survey; or

(4) Request and receive a license amendment under 902 KAR 100:020, Section 7(2) of these administrative regulations that authorizes radiation levels in unrestricted areas greater than those permitted by 902 KAR 100:020, Section 7(1) of these administrative regulations.

Section 15. Reports of Teletherapy Surveys, Checks, Tests, and Measurements.
A licensee shall furnish a copy of the records required in Sections 12, 13, and 14 of this administrative regulation and the output from the teletherapy source expressed as roentgens or rads per hour at one (1) meter from the source and determined during the full calibration required in Section 10 of this administrative regulation to the cabinet within thirty (30) days following completion of the action that initiated the record requirement.

Section 16. Five (5) Year Inspection.
(1) The licensee shall cause each teletherapy unit used for medical use to be fully inspected and serviced during source replacement or at intervals not to exceed five (5) years, whichever comes first, to assure proper functioning of the source exposure mechanism.
(2) Inspection and servicing of the teletherapy unit shall be performed by persons specifically licensed to do so by the cabinet, the U.S. Nuclear Regulatory Commission or an Agreement State.
(3) A licensee shall maintain a record of the inspection and servicing for the duration of the license. The record shall contain the inspector's name, the inspector's license number, the date of inspection, the manufacturer's name and model number and serial number for both the teletherapy unit and source, a list of components inspected, a list of components serviced and the type of service, a list of components replaced, and the signature of the inspector.

Section 17. Training for Teletherapy Physicist.
The licensee shall require the teletherapy physicist to:
(1) Be certified by the American Board of Radiology in:
  (a) Therapeutic radiological physics;
  (b) Roentgen-ray and gamma-ray physics;
  (c) X-ray and radium physics; or
  (d) Radiological physics; or
(2) Hold a master's or doctor's degree in physics, biophysics, radiological physics, or health physics, and have completed one (1) year of full-time training in therapeutic radiological physics and also one (1) year of full-time work experience under the supervision of a teletherapy physicist at a medical institution. To meet this requirement, the individual shall have performed the tasks listed in 902 KAR 100:073, Section 19 and Sections 10, 11 and 12 of this administrative regulation under the supervision of a teletherapy physicist during the year of work experience. (6 Ky.R. 217; eff. 11-7-79; Am. 12 Ky.R. 989; eff. 1-3-86; 16 Ky.R. 2524; **eff. 6-27-90**.)

KENTUCKY BOARD OF RESPIRATORY CARE

KRS 314A.230 Duty of treating respiratory care practitioner utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". www.lrc.ky.gov/Statutes/statute.aspx?id=30985

(1) A treating respiratory care practitioner who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.
(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of respiratory care services and in the provision of continuing education.
(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000
History: Created 2000 Ky. Acts ch. 376, sec. 14, effective July 14, 2000.

KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY

KRS 334A.200 Duty of treating speech-language pathologist or audiologist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth".
www.lrc.ky.gov/Statutes/statute.aspx?id=31917

(1) A treating speech-language pathologist or audiologist who provides or facilitates the use of telehealth shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.
(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and

(c) Utilize telehealth in the provision of speech-language pathology or audiology services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 14, 2000

History: Created 2000 Ky. Acts ch. 376, sec. 22, effective July 14, 2000.

Kentucky Board of Speech-Language Pathology & Audiology - 201 KAR 17:110. Telehealth and telepractice. www.lrc.ky.gov/kar/201/017/110.htm

RELATES TO: KRS 334A.200

STATUTORY AUTHORITY: KRS 334A.200

NECESSITY, FUNCTION, AND CONFORMITY: KRS 334A.200 requires the Board of Speech Language Pathology and Audiology to promulgate administrative regulations to implement the use of telehealth services by speech-language pathologists and audiologists. This administrative regulation establishes requirements for the use of telehealth services.

Section 1. Definitions.

(1) "Client" means the person receiving the services of the speech-language pathologist or audiologist and the representative thereof if required by law.

(2) "Telehealth" is defined by KRS 334A.200(3).

(3) "Telepractice" means the practice of speech language pathology or audiology as defined by KRS 334A.020(4) and KRS 334.020(6) respectively provided by using communication technology that is two (2) way, interactive, and simultaneously audio and video.

Section 2. Client Requirements.

A practitioner-patient relationship shall not commence via telehealth. An initial, in-person meeting for the practitioner and patient who prospectively utilize telehealth shall occur. A licensed health care practitioner may represent the licensee at the initial, in-person meeting. A licensee who uses telehealth to deliver speech language pathology or audiology services or who telepractices or the licensed healthcare practitioner representing the licensee shall, at the initial, in-person meeting with the client.

(1) Make reasonable attempts to verify the identify of the client;

(2) Obtain alternative means of contacting the client other than electronically;

(3) Provide to the client alternative means of contacting the licensee other than electronically;

(4) Document if the client has the necessary knowledge and skills to benefit from the type of telepractice provided by the licensee; and

(5) Inform the client in writing about:

(a) The limitations of using technology in the provision of telepractice;

(b) Potential risks to confidentiality of information due to technology in the provision of telepractice;

(c) Potential risks of disruption in the use of telepractice;

(d) When and how the licensee will respond to routine electronic messages;
(e) In what circumstances the licensee will use alternative communications for emergency purposes;
(f) Who else may have access to client communications with the licensee;
(g) How communications can be directed to a specific licensee;
(h) How the licensee stores electronic communications from the client; and
(i) That the licensee may elect to discontinue the provision of services through telehealth.

Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records.
A licensee using telehealth to deliver services or who telepractices shall:
(1) Limit the telepractice to the licensee's scope of practice;
(2) Maintain continuing competency or associate with a group who has experience in telehealth delivery of care;
(3) Use methods for protecting health information which shall include authentication and encryption technology;
(4) Limit access to that information to only those necessary for the provision of services or those required by law; and
(5) Ensure that confidential communications obtained and stored electronically cannot be recovered and accessed by unauthorized persons when the licensee disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law.
(1) A licensee using telehealth to deliver speech language pathology and audiology services and telepractice shall comply with:
(a) State law by being licensed to practice speech language pathology or audiology, whichever is being telepracticed, in the jurisdiction where the practitioner-patient relationship commenced; and
(b) Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with disabilities.
(2) If a person provides speech language pathology and audiology services via telepractice to a person physically located in Kentucky at the time the services are provided, that provider shall be licensed by the board.
(3) A person providing speech language and audiology services via telepractice from a physical location in Kentucky shall be licensed by the board. This person may be subject to licensure requirements in other state where the services are received by the client.

Section 5. Representation of Services and Code of Conduct. A licensee using telehealth to deliver services or who telepractices:
(1) Shall not engage in false, misleading, or deceptive advertising of telepractice; and
(2) Shall not split fees. (39 Ky.R. 918; 1463; 1680; **eff. 3-8-2013**).

DEPARTMENT OF WORKERS' CLAIMS

KRS 342.315. Medical evaluations by university medical schools -- Procedures -- Report - - Payment of costs -- Performance assessment of medical schools.
www.lrc.ky.gov/Statutes/statute.aspx?id=32471

(1) The commissioner shall contract with the University of Kentucky and the University of Louisville medical schools to evaluate workers who have had injuries or become affected by occupational diseases covered by this chapter. Referral for evaluation may be made to one (1) of the medical schools whenever a medical question is at issue.

(2) The physicians and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and opinions in the form prescribed by the commissioner. Except as otherwise provided in KRS 342.316, the clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically state in the order the reasons for rejecting that evidence.

(3) The commissioner or an administrative law judge may, upon the application of any party or upon his own motion, direct appointment by the commissioner, pursuant to subsection (1) of this section, of a medical evaluator to make any necessary medical examination of the employee. Such medical evaluator shall file with the commissioner within fifteen (15) days after such examination a written report. The medical evaluator appointed may charge a reasonable fee not exceeding fees established by the commissioner for those services.

(4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer or carrier shall pay the cost of the examination. Upon notice from the commissioner that an evaluation has been scheduled, the insurance carrier shall forward within seven (7) days to the employee the expenses of travel necessary to attend the evaluation at a rate equal to that paid to state employees for travel by private automobile while conducting state business.

(5) Upon claims in which it is finally determined that the injured worker was not the employee at the time of injury of an employer covered by this chapter, the special fund shall reimburse the carrier for any evaluation performed pursuant to this section for which the carrier has been erroneously compelled to make payment.

(6) Not less often than annually the designee of the secretary of the Cabinet for Health and Family Services shall assess the performance of the medical schools and render findings as to whether evaluations conducted under this section are being rendered in a timely manner, whether examinations are conducted in accordance with medically recognized techniques, whether impairment ratings are in conformity with standards prescribed by the "Guides to the Evaluation of Permanent Impairment," and whether coal workers' pneumoconiosis examinations are conducted in accordance with the standards prescribed in this chapter.

(7) The General Assembly finds that good public policy mandates the realization of the potential advantages, both economic and effectual, of the use of telemedicine and telehealth. The commissioner may, to the extent that he or she finds it feasible and appropriate, require the use

of telemedicine and telehealth practices, as authorized under KRS 194A.125, in the independent medical evaluation process required by this chapter.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1815, effective July 15, 2010; and ch. 90, sec. 3, effective July 15, 2010. -- Amended 2007 Ky. Acts ch. 24, sec. 29, effective June 26, 2007. -- Amended 2005 Ky. Acts ch. 99, sec. 611, effective June 20, 2005. - - Amended 2002 Ky. Acts ch. 340, sec. 1, effective July 15, 2002. -- Amended 2001 Ky. Acts ch. 57, sec. 2, effective June 21, 2001. -- Amended 2000 Ky. Acts ch. 514, sec. 22, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 566, effective July 15, 1998. -- Amended 1996 (1st Extra. Sess.) Ky. Acts ch. 1, sec. 15, effective December 12, 1996. -- Amended 1996 Ky. Acts ch. 355, sec. 11, effective July 15, 1996. -- Amended 1987 (1st Extra. Sess.) Ky. Acts ch. 1, sec. 40, effective January 4, 1988. -- Amended 1956 Ky. Acts ch. 77, sec. 11. -- Amended 1950 Ky. Acts ch. 188, sec. 2. -- Amended 1948 Ky. Acts ch. 151, sec. 3. -- Amended 1946 Ky. Acts ch. 23, sec. 3; and ch. 37, sec. 8. -- Amended 1944 Ky. Acts ch. 82, sec. 2. - - Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 4941.

Legislative Research Commission Note (7/15/2010). This section was amended by 2010 Ky. Acts chs. 24 and 90, which do not appear to be in conflict and have been codified together.

KENTUCKY APPLIED BEHAVIOR ANALYSIS LICENSING BOARD

KRS 319C.140 Patient's informed consent -- Confidentiality of medical information -- Administrative regulations governing telehealth services.

www.lrc.ky.gov/Statutes/statute.aspx?id=31305

(1) A treating behavior analyst or assistant behavior analyst who provides or facilitates the use of telehealth, shall ensure:
   (a) That the informed consent of the patient, or another appropriate person with authority to make the health-care treatment decision for the patient, is obtained before services are provided through telehealth; and
   (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:
   (a) Prevent abuse and fraud through the use of telehealth services;
   (b) Prevent fee-splitting through the use of telehealth services; and
   (c) Utilize telehealth in the provision of applied behavior analysis and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

Effective: July 15, 2010
History: Created 2010 Ky. Acts ch. 150, sec. 14, effective July 15, 2010.

Kentucky Applied Behavior Analysis Licensing Board - 201 KAR 43.100. Telehealth and telepractice. www.lrc.ky.gov/kar/201/043/100.htm

RELATES TO: KRS 319C.140(2)
STATUTORY AUTHORITY: KRS 319C.140(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 319C.140(2) requires the board to promulgate administrative regulations related to utilization of telehealth as a means of healthcare delivery. This administrative regulation establishes the requirements for telehealth and telepractice in applied behavior analysis.

Section 1. Requirements for Licensees Providing Applied Behavior Analytic Services via Telehealth.

(1) A licensee who provides applied behavior analytic services via telehealth shall:
   (a) Maintain competence with the technologies utilized, including understanding and adequately addressing the actual and potential impact of those technologies on clients, supervisees, or other professionals;
   (b) Maintain compliance with KRS Chapter 319C, 201 KAR Chapter 43, and all other applicable federal, state, and local laws;
   (c) At the onset of the delivery of care via telehealth, identify appropriate emergency response contacts local to the client so that those contacts shall be readily accessible in the event of an emergency;
   (d) Protect and maintain the confidentiality of data and information in accordance with all applicable federal, state, and local laws; and
   (e) Dispose of data and information only in accordance with federal, state, and local law and in a manner that protects the data and information from unauthorized access.

(2) Applied behavior analysis with a client shall not commence via telehealth.
   (a) An initial, in-person meeting for the licensee and client who prospectively utilize telehealth shall occur.
   (b) The licensee shall, at the initial, in-person meeting with the client:
      1. Make reasonable attempts to verify the identity of the client;
      2. Obtain alternative means of contacting the client other than electronically;
      3. Provide to the client alternative means of contacting the licensee other than electronically;
      4. Document if the client has the necessary knowledge and skills to benefit from the type of telehealth to be provided by the licensee; and
      5. Inform the client in writing about and obtain the client's informed written consent regarding:
         a. The limitations of using technology in the provision of applied behavior analytic services;

b. Potential risks to confidentiality of information due to technology in the provision of applied behavior analytic services;
c. Potential risks of disruption in the use of telehealth technology;
d. When and how the licensee will respond to routine electronic messages;
e. In what circumstances the licensee will use alternative communications for emergency purposes;
f. Who else may have access to client communications with the licensee;
g. How communications can be directed to a specific licensee;
h. How the licensee stores electronic communications from the client; and
i. That the licensee or client may elect to discontinue the provision of services through telehealth at any time.

Section 2. Jurisdictional Considerations.

(1) A person providing applied behavior analytic services via telehealth to a person physically located in Kentucky while services are provided shall be licensed by the board.
(2) A person providing applied behavior analytic services via telehealth from a physical location in Kentucky shall be licensed by the board and may be subject to licensure requirements in other states where the services are received by the client.

Section 3. Representation of Services and Code of Conduct.

A licensee using telehealth to deliver services shall not:
(1) Engage in false, misleading, or deceptive advertising; and
(2) Split fees. (40 Ky.R. 2649; 41 Ky.R. 35; eff. 8-1-2014.)

HOSPITALIZATION OF THE MENTALLY ILL

KRS 202A.028. Hospitalization by court order – Transportation – Release.
www.lrc.ky.gov/Statutes/statute.aspx?id=44467

(1) Following an examination by a qualified mental health professional and a certification by that professional that the person meets the criteria for involuntary hospitalization, a judge may order the person hospitalized for a period not to exceed seventy-two (72) hours, excluding weekends and holidays. For the purposes of this section, the qualified mental health professional shall be:
   (a) A staff member of a regional community program for mental health or individuals with an intellectual disability;
   (b) An individual qualified and licensed to perform the examination through the use of telehealth services; or
   (c) The psychiatrist ordered, subject to the court's discretion, to perform the required examination.

(2) Any person who has been admitted to a hospital under subsection (1) of this section shall be released from the hospital within seventy-two (72) hours, excluding weekends and holidays, unless further held under the applicable provisions of this chapter.

(3) Any person admitted to a hospital under subsection (1) of this section or transferred to a hospital while ordered hospitalized under subsection (1) of this section shall be transported from the person's home county by the sheriff of that county or other peace officer as ordered by the court. The sheriff or other peace officer may, upon agreement of a person authorized by the peace officer, authorize the cabinet, a private agency on contract with the cabinet, or an ambulance service designated by the cabinet to transport the person to the hospital. The transportation costs of the sheriff, other peace officer, ambulance service, or other private agency on contract with the cabinet shall be paid by the cabinet in accordance with an administrative regulation promulgated by the cabinet, pursuant to KRS Chapter 13A.

(4) Any person released from the hospital under subsection (2) of this section shall be transported to the person's county of discharge by a sheriff or other peace officer, by an ambulance service designated by the cabinet, or by other appropriate means of transportation which is consistent with the treatment plan of that person. The transportation cost of transporting the patient to the patient's county of discharge when performed by a peace officer, ambulance service, or other private agency on contract with the cabinet shall be paid by the cabinet in accordance with an administrative regulation issued by the cabinet pursuant to KRS Chapter 13A.

(5) No person who has been held under subsection (1) of this section shall be held in jail pending evaluation and transportation to the hospital.

Effective: June 24, 2015

History: Amended 2015 Ky. Acts ch. 61, sec. 2, effective June 24, 2015. -- Amended 2012 Ky. Acts ch. 146, sec. 33, effective July 12, 2012. -- Amended 2000 Ky. Acts ch. 487, sec. 1, effective July 14, 2000. -- Amended 1994 Ky. Acts ch. 498, sec. 2, effective July 15, 1994. -- Created 1988 Ky. Acts ch. 139, sec. 3, effective July 15, 1988.

RELIGIOUS, CHARITABLE, AND EDUCATIONAL SECURITIES – NONSTOCK, NONPROFIT CORP

KRS 273.442. Community action agency may participate in pilot project established in KRS 205.632
www.lrc.ky.gov/Statutes/statute.aspx?id=45359

A community action agency may participate in the pilot project established in KRS 205.632. The state administering agency shall work with the Department for Medicaid Services to effectuate the pilot project if community action agencies are deemed participating providers.
Effective: July 15, 2016
History: Created 2016 Ky. Acts ch. 126, sec. 3, effective July 15, 2016.

KENTUCKY BOARD OF MEDICAL LICENSURE

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine -
(*Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup of the Federation of State Medical Boards)* - Adopted April 2014)
http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf