

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 3:170

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 3:170 was held on November 21, 2012.

(2) The following individuals commented at the public hearing:

| <u>Name and Title</u> | <u>Organization/Agency/Other Entity</u> |
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| Rob Sprang, Director Co-Project Manager | Kentucky TeleCare Kentucky TeleHealth Network; UK HealthCare, University of Kentucky |
| Steve Shannon, executive director | The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) |

(3) The following individuals submitted written comments regarding 907 KAR 3:170:

| <u>Name and Title</u> | <u>Organization/Agency/Other Entity</u> |
|---|---|
| Jamie S. Burton, Chief Executive Officer | The Adanta Group Community Mental Health Center; Somerset, KY |
| Rob Sprang, Director Co-Project Manager | Kentucky TeleCare Kentucky TeleHealth Network; UK HealthCare, University of Kentucky |
| JD Miller, Corporate Vice President of Medical Affairs | Appalachian Regional Healthcare University of Louisville Telehealth Training Center, |
| Tim Bickel, Director Co-Project Manager | Kentucky Telehealth Network St. Claire Regional Medical Center Telehealth Training Center |
| Mary Horsley, Director | Trover Foundation Telehealth Training Center |
| Steve Fricker, Director | Seven Counties Services; Louisville, KY |
| Tony Zipple, Executive Director | Kentucky River Community Care; Hazard, KY |
| Mike Kadish, Interim Executive Director | Mountain Comprehensive Care Center; Prestonsburg, KY |
| Mots Bishnoi, Executive Director | The Kentucky Association of Regional |
| Steve Shannon, executive director | |

Marie Alagia Cull

Mental Health/Mental Retardation
Programs, Inc., (KARP)
On Behalf of KentuckyOne Health, Inc.

(4) The following individual from the promulgating agency responded to the comments received regarding 907 KAR 3:170:

| <u>Name and Title</u> | <u>Organization/Agency/Other Entity</u> |
|-------------------------------------|---|
| Stuart Owen, Regulation Coordinator | Department for Medicaid Services |

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Necessity, Function and Conformity Paragraph Regarding Managed Care Organizations

(a) Comment: Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center, stated the following:

“After reading the proposed changes to 907 KAR 3:170, I am very concerned about the future of outpatient psychiatric services Adanta’s clients receive from our outpatient clinics located across the Lake Cumberland area. As Chief Executive Officer of The Adanta Group Community Mental Health Center, representing one of the more rural areas of the state, and without a single city in the region greater than 15,000 population, our agency was an early adopter of Telehealth services.

Adanta’s decision to invest heavily in Telehealth was driven primarily by the consistent lack of available Psychiatrists and APRN’s in our rural area, as well as the commitment and authority to provide outpatient Medicaid services in our widely separated area of coverage. In addition, in preparation for expenses that we had knowledge were going to increase, namely the Kentucky Employees Retirement System (KERS) employer contributions, we had to develop plans for meeting the needs of our clients, as well as committing resources to the agency’s future existence that were efficient and effective.

It was clear to our agency’s Directors that by utilizing emerging Telehealth capabilities, Adanta would be able to provide an array of services to clients across our ten-county region without requiring vast amounts of time to be tied up in travel – both for the clients and the Prescribers. Over the course of 18 months, working with the University of Louisville’s Telehealth Program and the Kentucky Behavioral Telehealth Network (KBTN) we were able to develop and fully implement a secure HD-Telehealth video system compliant with KBTN and HIPAA. The Telehealth system includes a significant recurring data communication cost to our agency.

During the past year, Adanta’s three on-staff psychiatrists and the University of Louisville’s **10** contract psychiatrists have utilized this Telehealth system to provide **8,637** units of service to clients in 11 distinct locations throughout our region. As such, Telehealth has produced a positive, effective, and efficient outcome resulting not only in

clients being able to be seen quickly, but in also greatly reducing travel time and expense for both staff and clients. Our agency has capitalized on the efficiencies inherent in Telehealth, which is the goal of every organization that pursues this technology.

Consequently, after reviewing the proposed amendments to Kentucky Administrative Regulations regarding Telehealth Consultation Coverage and Reimbursement, both Staff and I have great concern with some of the areas contained within. The amended regulation contains several de-stabilizing statements which can and may force Adanta to 'power down' the very expensive investment in equipment. Briefly, the main concerns focus on two areas.

1. **Necessity, Function, and Conformity, page 1 line 21, and page 2 lines 1-6:**

'The coverage policies in this administrative regulation shall apply to 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. A managed care organization **shall not be required to reimburse the same amount for a Telehealth consultation as the department reimburses, but shall be authorized to reimburse as the department reimburses if it chooses to do so.**'

This amended language gives significant cause for concern that needed and/or required services *could* be denied or reduced *simply due to a managed care organization deciding the service is not significant or valuable enough for reimbursement to be provided.*

Transitioning back to the 'old way' of delivering services face-to-face for clients has the clear and devastating potential of limiting a client's access to care due to a limited number of Prescribers and the logistics involved in serving a widely separated region. The agency's lack of success in recruiting Prescribers is due in large part to the rural area and the inability of the agency to offer competitive salaries due to the employer's share of KERS contributions."

(b) Response: The language quoted in the Necessity, Function, and Conformity paragraph does not authorize a managed care organization (MCO) to not reimburse for a given service because the MCO decides the service is not significant or valuable enough for reimbursement. The MCOs are required, as the first part of the quoted statement indicates, to cover services in accordance with the policies established in 907 KAR 3:170.

The intent of the statement is to clarify that MCOs are not required to reimburse the same amount as DMS reimburses for a given service. For example, if DMS reimburses \$50.00 for a given service provided via Telehealth, an MCO is not required to also reimburse \$50.00 for the covered service that the MCO covered. Medical necessity, one of the coverage requirements in this administrative regulation, is the key component in

determining whether or not an MCO pays for a given service provided Telehealth.

(c) Comment: Marie Alagia Cull on behalf of KentuckyOne Health, Inc., stated the following:

“Pages 1, 2, lines 21, 1 to 6. This language seems to require the Medicaid Managed Care Organizations (MCOs) to provide coverage for Telehealth Services in the same manner as Medicaid as set forth in other regulations but at a negotiated rate that may deviate from the fee for service payment. This does not provide an option for the MCOs to provide coverage in excess or for more services than that currently provided under the Medicaid regulations. The MCOs should be allowed to cover more, but not fewer, services than currently covered in the Medicaid Program. This should also clarify that the MCOs are to reimburse the same for Telehealth services as for face to face consultations.”

(d) Response: Under certain conditions, managed care organizations (MCOs) are authorized to provide services in addition to the services they are required, by DMS, to cover; however, DMS prefers to not insert language addressing this in its regulations.

Regarding MCOs' reimbursement for services, the MCOs are not required to reimburse the same rate for a Telehealth consultation as for a face-to-face consultation.

(2) Subject: Reimbursement Section/MCO Reimbursement for Telehealth

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; JD Miller, Corporate Vice President of Medical Affairs at Appalachian Regional Healthcare; Tim Bickel, Director of the University of Louisville Telehealth Training Center and Co-Project Manager of the Kentucky Telehealth Network; Mary Horsley, Director of the St. Claire Regional Medical Center Telehealth Training Center; and Steve Fricker, Director of the Trover Foundation Telehealth Training Center stated the following:

“It is our belief that the managed care organizations **must** be required to reimburse for Telehealth encounters. It is preferable that the Telehealth encounters be reimbursed at the same rate as the Department for Medicaid Services. Please also review highlighted section page 38, lines 15-23, as this seems to state that an encounter will be paid at the same rate as a traditional face-to-face encounter.”

Rob Sprang, JD Miller, Tim Bickel, Mary Horsley and Steve Fricker referred to the following statement in Section 5 of the administrative regulation:

“(1) The department shall reimburse a Telehealth provider for a Telehealth consultation:
(a) Except for a Telehealth consultation provided by an APRN~~[ARNP]~~ or CMHC, an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010;
(b) If a CMHC, in accordance with 907 KAR 1:045; or

(c) If provided by an APRN~~[ARNP]~~, an amount equal to the amount paid for a comparable in person service in accordance with 907 KAR 1:104.”

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) requested that managed care organizations be required to pay for Telehealth services “preferably at the Department for Medicaid Services rates.”

(b) Response: The MCOs are required to cover services in accordance with the policies established in 907 KAR 3:170. The MCOs are not required to reimburse the same amount as DMS reimburses for a given service. The MCOs negotiate contracts with their respective providers and MCO reimbursement for services is a matter between the MCOs and the providers in their respective networks. DMS did not mandate, in its agreements with MCOs, that MCOs reimburse providers the same amounts as DMS reimburses providers and DMS is not going to impose such a requirement on an MCO in an administrative regulation.

DMS is inserting language in Section 5(1) in an “amended after comments” regulation to clarify that the managed care organizations are not required to reimburse the same amount as DMS reimburses for a Telehealth consultation.

(3) Subject: Psychiatrists Under Contract With a Community Mental Health Center

(a) Comment: Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center, indicated that the following is The Adanta Group’s second area of concern with the regulation:

“Section 3: Telehealth Consultation Coverage in a Community Mental Health Center, page 18, lines 15-22:

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 directly employed** by the community mental health center.

It appears that the net result of this statement indicates that Adanta would not be able to utilize contracted psychiatrists via the University of Louisville Telehealth Program.

While the agency currently uses the contracted psychiatrists for only a small percentage of our services, their expertise and willingness to provide services on a timely and short notice (in the event of psychiatrist or APRN illness or turnover) is extremely important to a rural center like ours and is essentially the life of the organization for outpatient services.”

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“Under Section 4, the Community Mental Health Center section, language of ‘or contracted’ was added to the person who may deliver a Telehealth consultation service. As explained within the comment in the regulation, many Community Mental Health Centers do not ‘directly employ’ psychiatrists, but contract with universities such as the University of Kentucky and the University of Louisville. Recruiting psychiatrists to a rural or very rural area has been extremely difficult and unsuccessful in some remote locations. Alternatively, some Community Mental Health Centers contract with local psychiatrists to deliver the Telehealth service. Additional comments may be found within the submitted regulation.”

Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following comments on a draft of the administrative regulation:

“Community Mental Health Centers (CMHC), particularly those in rural and very rural areas, do not have enough psychiatrists or may not have any psychiatrist ‘employed by’ the Centers, to deliver needed services. In the rural and more rural areas, some CMHCs do not directly employ psychiatrists, for numerous reasons: the cost to employ a full-time psychiatrist is prohibitive relative to the practice size, psychiatrists are not interested in locating or re-locating to a rural area or a very rural area; with the implementation of telehealth several years ago, many psychiatrists choose to work for a larger organization in a more urban area or closer to their home and “contract out” their services. Requiring psychiatrists or other types of providers to be directly employed by a CMHC will create an undesirable and devastating hole in the provision of services provided by one of the Commonwealth’s largest safety net providers. The few psychiatrists that are employed by rural and very rural CMHCs will soon leave

employment due to the large caseloads they will be required to pick up due to lack of available and/or 'willing to be employed in a rural or very rural area' psychiatrists.”

(b) Response: DMS is revising the language in an “amended after comments” regulation to authorize an agent of a community mental health center to provide Telehealth consultations. The amended language (in boldface) reads as follows:

“(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) Subject: Definition of “Face-to-Face”

(a) Comment: Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP), state the following:

“It is recommended page 3 line 7 the word ‘Not’ should be deleted to include telehealth in the definition of face-to-face. The greatly enhanced tele-video technology results in comparable therapeutic outcomes between traditional and telehealth therapy. The new language will read:

(10) “Face-to-face” means:

(a) In person; and

(b) Via Telehealth”.

Mr. Shannon also stated, “the inclusion of telehealth in the definition of face-to-face and maintaining the current array of services and providers within a CMHC will continue to move the utilization of telehealth technology forward, expand access to underserved areas and improve outcomes for individuals served and supported by CMHCs.”

(b) Response: Given the advances in technology – for example, “face time” and similar mechanisms in which two (2) individuals do not have to be physically present at the same location – the face-to-face requirement is arguably outdated. However, the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), through which CMS has agreed to provide federal funding and with which the administration regulation must comport, states the following:

“Coverage for services rendered through Telehealth service, provided at the originating site, are covered to the same extent the service and the provider are covered when not furnished through Telehealth service and are considered an alternative way of providing covered services that are typically provided face-to-face and thus do not constitute a change in Medicaid coverage.”

The approved state plan amendment distinguishes a Telehealth setting from a “face-to-face” setting and if DMS altered the policy, in regulation and practice, by equating Telehealth to “face-to-face”, DMS would be contradicting the approved state plan amendment and, therefore, jeopardizing the receipt of federal funds for Telehealth services.

To change the policy in a responsible manner, DMS would need to submit a new state plan amendment to CMS and DMS will consider doing so.

(c) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 3, lines 5 through 7. Excluding Telehealth from the definition of “face to face” raises the same issues as addressed with ‘direct physician contact.’”

(d) Response: Please see the above response – (b).

(5) Subject: Section 4 – Telehealth Consultation Coverage in a Community Mental Health Center

(a) Comment: Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP), state the following:

“It is recommended Section 4. Telehealth Consultation Coverage in a Community Mental Health Center. (page 18, line 6 through page 19 line 23) be deleted from the proposed regulation. The proposed language significantly reduces both the services available and providers eligible in a tele-health environment thereby reducing access for many individuals. The regulation should then be renumbered accordingly.”

Mr. Shannon also stated, “the inclusion of telehealth in the definition of face-to-face and maintaining the current array of services and providers within a CMHC will continue to move the utilization of telehealth technology forward, expand access to underserved areas and improve outcomes for individuals served and supported by CMHCs.”

(b) Response: The primary purpose of the amended regulation is to make the regulation comport with the policies and requirements represented in the “state plan amendment” (regarding Telehealth consultations) approved by the Centers for Medicare and Medicaid Services (CMS). As background, DMS submitted a state plan amendment which mirrored the current regulation (meaning the current adopted regulation and not the amended version DMS filed with the Legislative Research Commission on October 8, 2012. During CMS’s review of the state plan amendment, CMS noted discrepancies between DMS policies for face-to-face services and the policies stated in the Telehealth state plan amendment. For example, DMS imposed certain limits or restrictions on the amount of services, or did not authorize certain practitioners to provide certain services, or required certain practitioners to be employed by another provider or entity rather than

independently provide services. As a result, CMS required that all program restrictions and limits – as stated in DMS’s state plan for services not provide via Telehealth – must also be imposed for the same services being provided via Telehealth.

In preparing the section of this amended regulation which establishes Telehealth requirements in a community mental health center setting, DMS examined the community mental health center requirements (including service limits and restrictions as well as practitioner limits and restrictions.) In preparing the non-CMHC section of the regulation DMS, likewise, reviewed the various program restrictions and limits for services in those settings. Even though the services may be the same, there are some restrictions in the DMS program for CMHC services that do not exist in non-CMHC settings.

The merits of different policies and restrictions could be debated; however, DMS has to ensure that the policies stated in the Telehealth regulation comply with the state plan amendment approved by CMS (which again, is the mechanism through which DMS receives federal funding for Telehealth consultation coverage.) Consequently, DMS distinguishes the policies in the regulation based on whether services are provided in a community mental health center or not in a community mental health center.

DMS that the definition of “face-to-face” may be outdated; however, the state plan amendment approved by CMS differentiates Telehealth from “face-to-face” and DMS would need to submit a new state plan amendment to address the matter in order to change the policy in a way that would ensure federal funding for the policy. DMS will consider doing so.

(6) Subject: Rescind Deletion of Section 3

(a) Comment: Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP), state the following:

“It is recommended the proposed deletion of Section 3. Coverage of Telehealth by a Community Mental Health Center. (page 27 line 20 – page 32 line 17) be rescinded. This change re-establishes the utilization of telehealth as enacted by the changes to 907 KAR 3:170 in February of 2009. The regulation should then be renumbered accordingly.”

Mr. Shannon also stated, “the inclusion of telehealth in the definition of face-to-face and maintaining the current array of services and providers within a CMHC will continue to move the utilization of telehealth technology forward, expand access to underserved areas and improve outcomes for individuals served and supported by CMHCs.”

(b) Response: Please see the response (b) under subject (5) as the same response applies here.

(7) Subject: Add Group Therapy Via Telehealth as an Option in a CMHC

(a) Comment: Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP), state the following:

“Just spoke to a CEO whose CMHC has used telehealth to do group therapy. Bad weather prevented the therapist from getting to the clinic office from another office she was working at that day. The group participants were able to get to the clinic office. The CMHC used telehealth to do the group with the therapist being in one site and the group in the second site. I did not think of the therapist/clinician in one site and the group in a second site.

The CEO reported he was opposed to telehealth services until he witnessed it and heard from clinicians how effective it has been now he is a telehealth convert.”

(b) Response: As group psychotherapy is authorized by the approved state plan and has no restriction or limit in the CMHC program which precludes it from being covered if provided via Telehealth, DMS is adding it to the list of covered Telehealth consultations in a CMHC setting in an “amended after comments” regulation.

(8) Subject: Allow Mental Health Practitioners (Non-CMHC) to be Employed by Hospitals or Clinics

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network stated the following at the public hearing:

“But, the comments specifically, beginning on Page 9, Line 18, there are several notes of different mental health professionals working in a non-community mental health center. And, the notes in the regulation itself focus exclusively on those providers that are employed by a psychiatrist. But, as I understand, those providers can also be employed by a hospital or a clinic. And, so we need to be able to expand those regs. And, there are blocks of language where I would like to add in addition to just employed by a psychiatrist, employed by a hospital and employed by a clinic.

And, those blocks of language are a psychologist that is noted on Page 9, Lines 18 to 23. A licensed professional clinical counselor that is on Page 10, Lines 2 through 8. A licensed clinical social worker that's noted on Page 10, Lines 9 through 15. Licensed marriage and family therapist on Page 10, Lines 16 through 22. A psychologist, Page 11, Lines 4 through 11. Licensed clinical professional--professional clinical counselor, Page 11, Line 13 through 19. Licensed clinical social worker, Page 11, Line 20 through Page 12, Line 3. And, a licensed marriage and family therapist, Page 12, Line 4 through 10.”

Mr. Sprang also stated the following at the public hearing:

“We have the same--the same requirements or the same concerns noted over and over again in those same--what we need is the addition of employed in a hospital or a clinic for a psychologist on Page 12, Line 20 through Page 13, Line 5. A licensed clinical--

professional clinical counselor Page 13, Line 6 through Line 12. A licensed clinical social worker, Page 13, Line 13 through 19. Licensed marriage and family therapist, Page 13, Line 20 through Page 14, Line 3.”

(b) Response: The only settings in which the Department for Medicaid Services reimburses for mental or behavioral health care in an inpatient hospital are in an inpatient psychiatric hospital or a psychiatric distinct part unit of an acute care hospital.

In the inpatient setting, DMS reimburses the hospital, rather than individual practitioners, for psychiatric care on a per diem basis in which the reimbursement (which is made to the hospital) is not itemized but is reimbursement for the entire array of psychiatric care. The hospital’s reimbursement to individual practitioners is a matter between the hospital and staff. In contract, this administrative regulation establishes reimbursement for Telehealth consultations in which a given Telehealth consultation is a stand-alone service reimbursed by the Department for Medicaid Services (DMS).

The state plan amendment approved by the Centers for Medicare and Medicaid (CMS) and through which CMS provides federal funding to DMS for Telehealth consultations, requires DMS to apply all program restrictions in face-to-face settings for services covered via Telehealth. DMS cannot reimburse for services provided via Telehealth if it does not reimburse for the service in a face-to-face setting.

The only “clinic” settings in which DMS reimburses for mental health or behavioral health care are in federally qualified health care centers, rural health clinics, and primary care centers. In those settings, DMS covers behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider’s legally authorized scope of service. [907 KAR 1:054, Primary care center and federally-qualified health center services, Section 2(3)(e) and 907 KAR 1:082, Rural health clinic services, Section 2(6).] However, the state plan amendment approved by CMS only authorizes licensed psychologists, licensed professional clinical counselors, licensed clinical social workers and licensed marriage and family therapists to provide services via Telehealth if employed by a psychiatrist (or if employed or an agent of a community mental health center.) DMS cannot exceed the scope or coverage of Telehealth consultations authorized by the state plan amendment as federal funding is only provided within the parameters of the approved state plan amendment.

(9) Subject: Allow Nutritional Therapists/Dietitians (Non-CMHC) to be Employed by Hospitals or Clinics

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network stated the following at the public hearing:

“Other suggested changes that we have, it refers to medical nutrition therapy. And, the locations where medical nutritional therapist, licensed dietitian are employed is listed in the reg as employed by physician, federally qualified health center, rural health clinic,

primary care center or department for public health. What is not mentioned is hospital where many dietitians are employed. And, so on Page 14, Line 7, we would like to add hospital. On Page 14, Line 10, we would like to add hospital. On Page 14, Line 15, add hospital. Page 14, Line 18, we would like to add an employment in a hospital. On Page 15, Line 9, we would like to add a hospital as place of employment. And, on Line (sic) 15, Line 12, we would like to add hospital as a place of employment.”

(d) Response: Regarding nutrition services in an inpatient hospital setting, DMS reimburses for inpatient hospital care on a diagnosis-related group (DRG) basis or per diem basis depending on the type of hospital rather than on an itemized service-by-service basis as DMS does regarding Telehealth consultations. In the inpatient hospital scenarios, DMS reimburses the hospital for the full array of care provided to the given recipient (again, either via a DRG payment or per diem payment.) The inpatient hospital may pay practitioners as it chooses, but DMS’s reimbursement obligation to the inpatient hospital is satisfied by DMS’s DRG or per diem payment.

In contrast, DMS reimburses for outpatient hospital services on an interim basis (a cost-to-charge ratio) and then settles to cost at fiscal year’s end. DMS covers medical nutrition services in an outpatient hospital setting and the state plan amendment approved by CMS authorizes individual medical nutrition services to be provided via Telehealth and by licensed dietitians and certified nutritionists. Consequently, DMS is inserting language in an “amended after comments” regulation to authorize licensed dietitians and certified nutritionists to provide individual medical nutrition therapy services (via Telehealth) in an outpatient hospital setting. DMS is also adding outpatient hospital as an authorized setting for a licensed dietitian to provide diabetes self-management education via a Telehealth consultation.

(10) Subject: Therapists and Inpatient Hospitals/Inpatient Physical Rehabilitation Facilities/Skilled Nursing Facilities

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network stated the following at the public hearing:

“Then we have the same comment that is going to repeat--be repeated several times for occupational therapy, physical therapy and speech language therapy. There are places noted of employment. What is not noted are inpatient hospitals, inpatient physical rehab facilities and skilled nursing facilities. And, it's my understanding that currently occupational physical therapists and speech language therapists are all reimbursed, if they work in those three facilities.

So, beginning on Page 15, Line 15, we would like to have the addition of inpatient hospital, inpatient rehab and skilled nursing facility.

We would like to make that same comment added to Page 16, Line 6, for physical therapy. One Page 16, Line 20, for speech therapy.”

(b) Response: Regarding practitioners working for inpatient hospitals, this administrative regulation establishes reimbursement for Telehealth consultations in which a given Telehealth consultation is a stand-alone service reimbursed by the Department for Medicaid Services (DMS.) DMS reimburses inpatient hospitals on either a diagnosis related group (DRG) basis or a per diem rate basis.

In the DRG scenario, DMS's reimbursement represents all of the hospital's reimbursement for care to a given recipient, and DMS does not itemize and separately reimburse for each given service or component of care. Rather DMS's reimbursement to the hospital represents reimbursement (a given DRG) for the entire episode of care. How the hospital reimburses its practitioners is a matter between the hospital and the practitioner as DMS does not reimburse the practitioners for each given service or component of care.

Similarly with per diem reimbursement for inpatient hospitals, DMS does not itemize reimbursement and reimburse for each given service or component of care, rather DMS pays the hospital a per diem amount representing reimbursement for the entire scope of care. Again, the hospital's reimbursement to practitioners is a matter between the hospital and the practitioner.

DMS does not oppose hospitals employing or contracting with staff who provide services via Telehealth, but reimbursement in those scenarios is a matter between the hospital and the practitioner. Meaning, if the hospital wants to pay a given practitioner a certain amount of the DRG or per diem rate it received from DMS it is free to do so but DMS will not reimburse the practitioner as DMS has already reimbursed the hospital (a DRG or per diem rate) for the episode of care provided to the recipient.

Regarding nursing facilities, DMS does reimburse for occupational therapy, physical therapy and speech therapy provided in a nursing facility as an ancillary service separate from the nursing facility's "standard price" reimbursement. As a result, DMS is inserting language in an "amended after comments" regulation establishing that it will reimburse for the therapies in a nursing facility setting provided via Telehealth.

(11) Subject: Neurobehavioral Status Exam

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network stated the following at the public hearing:

"And, then we do have a comment for a--on Page 17, beginning at Line 11, a neuro behavioral status exam provided by different providers. And, one of the notes is that the psychologist must be--the physician or psychiatrist that does the neuro--that supervises the psychologist must be--must interact directly with recipient during the encounter. And, I believe in a supervised relationships that they have, that that supervision doesn't necessarily have to occur with the patient. And, so noted on Lines 19 and 20 on Page 17, I don't believe that they have to have direct contact, but can be supervised by the psychiatrist or the physician."

(b) Response: The state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) and through which CMS provides federal funding for DMS's coverage of Telehealth consultations requires that a psychiatrist must interact with the recipient during a Telehealth consultation provided by a licensed psychologist in a setting that is not a community mental health center. DMS's regulation must comport with the approved state plan amendment to ensure DMS's receipt of federal funding for services provided via Telehealth.

(12) Subject: Mistake - Licensed Marriage and Family Therapist Should Replace Licensed Dietitian

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network stated the following at the public hearing:

"Also there seems to be just a mistake on Line 12--I'm sorry, Page 12, Line 10. It is noted licensed dietitian, but it is in the section licensed marriage and family therapist. So, I believe that should be substituted."

Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following: "Page 12 through several pages, the term "licensed dietitian" is inserted where other practitioners should be listed. This appears to be a typographical error."

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) noted the erroneous listing of "licensed dietitian" rather than the correct term of "licensed marriage and family therapist."

(b) Response: DMS is correcting the mistakes (it occurred in two locations) in an "amended after comments" regulation.

(13) Subject: Community Mental Health Service Definition

(a) Comment: Jamie S. Burton, Chief Executive Officer of the the Adanta Group Community Mental Health Center; Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; JD Miller, Corporate Vice President of Medical Affairs of Appalachian Regional Healthcare; Tim Bickel, Director of the University of Louisville Telehealth Training Center and Co-Project Manager of the Kentucky Telehealth Network; Mary Horsley, Director of the St. Claire Regional Medical Center Telehealth Training Center; and Steve Fricker, Director of the Trover Foundation Telehealth Training Center requested the following changes (underlined language) to

the definition of community mental health center and noted that the recommendation is based on the January 2008 Community Mental Health Services Manual:

“(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.

(a) A community mental health center employs or contracts with the following licensed or credential staff as defined in the Department for Medicaid Services, Community Mental Health Center Services Manual (current edition), who may provide a telehealth service: Comment: All comments and suggestions are based on January 2008 Community Mental Health Center Services Manual

1. Licensed psychiatrist;
2. Licensed physician;
3. Licensed advanced practice registered nurse;
4. A psychologist:
 - a. With a license in accordance with KRS 319.010(5); and
 - b. With a doctorate degree in psychology; or
5. A person credentialed as a certified psychologist or as a licensed psychological associate in accordance with KRS 319.053; or
6. A person currently authorized to use the title “certified psychologist with autonomous functioning” or “licensed psychological practitioner” in accordance with KRS 319.056; or
7. A person currently authorized to use the title “certified psychologist” or “licensed psychological associate” in accordance with KRS 319.056; or
8. Licensed clinical social worker licensed under the provisions of KRS 335.100 ; or
9. A certified social worker licensed under the provisions of KRS 335.080 with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health and mental retardation program;
10. Psychiatric registered nurse A psychiatric registered nurse is defined by Medicaid as a registered nurse, licensed in the State of Kentucky with one of the following combinations of education and experience:
 - (a) Master of Science in Nursing (MSN) with specialty in psychiatric or mental health nursing. No experience.
 - (b) Four-year (4) educational program, with a Bachelor of Science in Nursing (BSN) and a minimum of one (1) year of experience in a mental health setting.
 - (c) Three-year (3) educational program Diploma graduate with two (2) years of experience in a mental health setting.
 - (d) Two-year (2) educational program Associate Degree in Nursing (AND) with three (3) years of experience in a mental health setting.
 - (e) Effective July 1, 1989, any level of education with American Nursing Association (ANA) certification as a psychiatric and mental health nurse.

(f) Any registered nurse employed by a participating mental health center in Kentucky on June 30, 1981 shall be considered a psychiatric nurse if their employment with the center continues, for the purpose of providing Medicaid Program reimbursable services.

11. (1) Professional Equivalent: A professional equivalent is defined as an individual who by virtue of a combination of education and experience in the Mental Health field is deemed qualified by the Agency and the Professional Equivalency Review Committee of the Department for Medicaid Services to provide mental health services.

The general combination of education and experience is as follows:

a. Bachelor's degree, identical field, three (3) years full-time equivalent supervised experience;

b. Master's degree, identical field, six (6) months full-time equivalent supervised experience;

c. Doctorate degree, identical field. COMMENT: The Department for Medicaid Services reimburses community mental health center providers for Professional Equivalents under the Department for Medicaid Services, Community Mental Health Center Services Manual, January 2008 edition.

12. Licensed Marriage and Family therapist in accordance with KRS 335.300(2);

13. Licensed Professional Clinical Counselor in accordance with KRS 335.500(3);

14. Licensed Professional Counselor Associate in accordance with KRS 335.500(4);

15. Psychiatric Resident Physician in accordance with KRS 311.571.”

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) requested that the language be added to the definition of community mental health center and also stated:

“Professional equivalent’ was added, which is currently not within the regulation as it exists today. This designation of professional staff is recognized by the Department for Medicaid Services, and it is our suggestion to include this staff within the proposed changes.”

(b) Response: DMS agrees that the recommended language is stated in the Community Mental Health Services Manual as it is a list of CMHC staff or /practitioners; however, DMS thinks it is inappropriate to be inserted as a definition of a CMHC and states policies rather than a definition. The Legislative Research Commission, which enforces the chapter of statutes establishing administrative regulation requirements (KRS Chapter 13A) opposes policy statements in definitions and requires such statements to be stated in the body of an administrative regulation rather than in the definitions section of an administrative regulation.

Professional equivalents are not included among the practitioners authorized to provide Telehealth consultations in the state plan amendment approved by the Centers for

Medicare and Medicaid Services (CMS) and through which CMS provides federal funding to the Department for Medicaid Services for its Telehealth coverage. Consequently, DMS is not adding it to the list of authorized Telehealth practitioners in the administrative regulation.

(14) Subject: Health Care Provider Definition

(a) Comment: Jamie S. Burton, Chief Executive Officer of the the Adanta Group Community Mental Health Center; Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; JD Miller, Corporate Vice President of Medical Affairs of Appalachian Regional Healthcare; Tim Bickel, Director of the University of Louisville Telehealth Training Center and Co-Project Manager of the Kentucky Telehealth Network; Mary Horsley, Director of the St. Claire Regional Medical Center Telehealth Training Center; and Steve Fricker, Director of the Trover Foundation Telehealth Training Center made the following comments (bold-faced, italicized and underlined language) regarding the definition of "health care provider":

(13) "Health care provider" means a:

- (a) Currently enrolled Medicaid provider in accordance with 907 KAR 1:672;
- (b) Currently participating Medicaid provider in accordance with 907 KAR 1:671; and
- (c)1. Licensed physician;
- 2. Licensed advanced practice registered nurse;
- 3. Physician assistant working under a supervising physician;
- 4. Licensed dentist;
- 5. Licensed oral surgeon; **Comment: Not listed under 907 KAR 1:671 or 907 KAR 1:672**
- 6. A psychologist; **Comment: Not listed under 907 KAR 1:671 or 907 KAR 1:672**
 - a. With a license in accordance with KRS 319.010(5); and
 - b. With a doctorate degree in psychology;
- 7. Licensed clinical social worker; **Comment: Not listed under 907 KAR 1:671 or 907 KAR 1:672**
- 8. Chiropractor;
- 9. Licensed optometrist; or
- 10. Community mental health center **Comment: Not listed under 907 KAR 1:671 or 907 KAR 1:672.**

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) also noted that the professionals are not included as displayed above.

(b) Response: 907 KAR 1:671 does not list any provider types. 907 KAR 1:672 does list

provider types that are required - by KRS 205.560(12) - to be credentialed, but DMS enrolls other provider types which are not required by Kentucky law to be credentialed. The credentialing requirement in Kentucky law is not a pre-requisite for all provider types.

Below are the definitions of credentialed provider and noncredentialed provider as stated in 907 KAR 1:672:

“(4) "Credentialed provider" means a provider that is required to complete the credentialing process in accordance with KRS 205.560(12) and (13) and includes the following individuals who apply for enrollment in the Medicaid Program:

- (a) A dentist;
- (b) A physician;
- (c) An audiologist;
- (d) A certified registered nurse anesthetist;
- (e) An optometrist;
- (f) An advance registered nurse practitioner;
- (g) A podiatrist;
- (h) A chiropractor; or
- (i) A physician assistant.”

“(12) "Noncredentialed provider" means a provider that is not required to complete the credentialing process in accordance with KRS 205.560(12) and includes any individual or entity not identified in subsection (4) of this section.”

As the list of practitioners is unnecessary, DMS is revising the definition in an “amended after comments” regulation as follows:

“(13) "Health care provider" means a:

- (a) Currently enrolled Medicaid provider in accordance with 907 KAR 1:672; and
- (b) Currently participating Medicaid provider in accordance with 907 KAR 1:671.”

(c) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 3, lines 14 through 23, Page 4, provides a cumbersome definition of “health care provider.” KRS 205.559(1), which sets forth the requirements for telehealth reimbursement, contains the following language: “... Shall provide reimbursement for a telehealth consultation that is provided by a Medicaid-participating provider...” This is a better way to address this issue and obviates the necessity of amending the regulation every time a new provider is recognized by Medicaid.”

(d) Response: DMS agrees that a list is cumbersome and also unnecessary and is revising the definition in an “amended after comments” regulation as follows:

“(13) "Health care provider" means a:

- (a) Currently enrolled Medicaid provider in accordance with 907 KAR 1:672; and
(b) Currently participating Medicaid provider in accordance with 907 KAR 1:671.

(15) Subject: Hub Site Definition/Place of Service

(a) Comment: Jamie S. Burton, Chief Executive Officer of the the Adanta Group Community Mental Health Center; Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; JD Miller, Corporate Vice President of Medical Affairs of Appalachian Regional Healthcare; Tim Bickel, Director of the University of Louisville Telehealth Training Center and Co-Project Manager of the Kentucky Telehealth Network; Mary Horsley, Director of the St. Claire Regional Medical Center Telehealth Training Center; and Steve Fricker, Director of the Trover Foundation Telehealth Training Center stated the following regarding the definition of hub site as being “considered the place of service.”

“National rules for licensure, reimbursement and privileging/credentialing consider the location of the patient as the place of service. Under the language stated here, out-of-state providers could practice in Kentucky without a Kentucky license. This is a contested point in federal policy, but currently the place of service is considered the location of the patient during the encounter.”

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“‘Place of service’ is compared to national rules for licensure, reimbursement, reimbursement, and privileging/credentialing which consider the place of service as the location of the patient, not location of where the Telehealth provider performs Telehealth as currently written in regulation and present in the regulation just filed. This is a concern in that out-of-state providers could practice in Kentucky without a license.”

(b) Response: DMS appreciates the information. The state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) and under which CMS provides federal funding for the Telehealth program states that the “distant or hub site is the location of the provider and is considered the place of service.”

A national Medicaid website regarding “telemedicine” also portrays the hub site and spoke site as the regulation does. Below is language from the website followed by a link to it:

“Distant or Hub site: Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating or Spoke site: Location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.”

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

DMS is open to the concept of the patient’s location as being the place of service, but cannot amend the requirement at this time as it would contradict the state plan amendment approved by CMS.

(c) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 4, lines 16 through 18, Page 6, lines 14, 15, Page 6, line 23, and Page 7, line 1 use the terms ‘hub site,’ ‘spoke-site’ and ‘Telehealth site.’ This terminology is reminiscent of an early form of Telemedicine. It would be more appropriate to use the terms ‘referring site’ and ‘consulting site.’ The referring site is the site at which the patient is located and receives the facility fee. The consulting site is the site at which the professional consultation is being provided and which receives the professional fee. With much of telecommunication moving to ‘cloud’ typology, secure Internet protocols are being used. With the trends in health care reform, consultations may not take place at a ‘spoke-site’ but rather at a hospital, clinic, or other health care provider – which may become the patient’s home.”

Ms. Cull also stated the following:

“Page 6, line 23 and Page 7, line 1. The term ‘Telehealth site’ comes directly from 907 KAR 3:170. We recommend that the terminology ‘hub site’ or ‘spoke site’ be changed to ‘consulting site’ or ‘referral site.’

(d) Response: Please see the response – stated in (b) above – under this subject.

(16) Subject: Exempt CMHCs from Referral Requirement

(a) Comment: Jamie S. Burton, Chief Executive Officer of the the Adanta Group Community Mental Health Center; Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; JD Miller, Corporate Vice President of Medical Affairs of Appalachian Regional Healthcare; Tim Bickel, Director of the University of Louisville Telehealth Training Center and Co-Project Manager of the Kentucky Telehealth Network; Mary Horsley, Director of the St. Claire Regional Medical Center Telehealth Training Center; and Steve Fricker, Director of the Trover Foundation Telehealth Training Center requested the following exemption (bold-faced, underlined and italicized language) to community mental health centers:

“(5) A telehealth consultation shall require:

- (a) The use of two (2) way interactive video;
- (b) A referral by a health care provider ***unless provided in a community mental health center place of service.***

Additionally, Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) requested that the bold-faced language above be inserted into the administrative regulation.

(b) Response: DMS notes that a community mental health center is listed as a health care provider in the definition of health care provider – Section 1(13) – and is also a setting in which Telehealth consultations may be provided. Thus, a practitioner at a CMHC is authorized to refer an individual to receive a Telehealth consultation from a practitioner within the community mental health center.

(17) Subject: Direct Physician Contact Requirement

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 2, lines 22, 23. Including the term “direct physician contact” seems to contravene the purpose of Telehealth consultation. The “billing physician” may be the Telehealth consultant who is “virtually” rather than “physically” present to examine, treat or diagnose the patient. A clinician may be with the patient at the patient’s location following physician orders regarding the Tele-consultation. A clinician could be a physician, an APRN or other Allied Health professional.”

(b) Response: DMS is required, per the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) through which CMS provides federal funding to DMS for Telehealth consultations, to apply all program restrictions in face-to-face settings for services covered via Telehealth. 907 KAR 3:005 is the Medicaid administration regulation which establishes the service and coverage requirements and policies for physicians’ services in the Medicaid program and it requires direct physician contact as stated in Section 3(2) and (3) which is quoted below:

“(2) Direct physician contact between the billing physician and recipient shall not be required for:

- (a) A service provided by a 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;
- (b) A service provided by a locum tenens physician who provides direct physician contact;

- (c) 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;
 - (d) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;
 - (e) A preauthorized sleep disorder service if provided in a physician operated and supervised sleep disorder diagnostic center;
 - (f) A telehealth consultation provided by a consulting medical specialist in accordance with 907 KAR 3:170; or
 - (g) A service provided by a physician assistant in accordance with Section 7 of this administrative regulation.
- (3) A service provided by an individual who meets the definition of other licensed medical professional shall be covered if:
- (a) The individual is employed by the supervising physician;
 - (b) The individual is licensed in the state of practice; and
 - (c) The supervising physician has direct physician contact with the recipient.”

Section 3(2)(f) exempts “a Telehealth consultation provided by a consulting medical specialist” from the direct physician contact requirement. However, DMS does not view a physical therapist, speech language-pathologist, or an occupational therapist as a medical specialist based on the definition of the term medical specialist

The Free Dictionary, Dictionary.com, and Bee Dictionary (websites pasted below) all define a medical specialist as practicing “one branch of medicine.” Free Dictionary lists medical practitioners (predominantly physicians) but does not list physical therapists, speech-language pathologists, or occupational therapists as medical specialists.

<http://www.thefreedictionary.com/medical+specialist>

<http://dictionary.reference.com/browse/medical+specialist?s=t>

http://www.beedictionary.com/meaning/medical_specialist

The Merriam-Webster dictionary defines a specialist as “a medical practitioner whose practice is limited to a particular class of patients (as children) or of diseases (as skin diseases) or of technique (as surgery); *especially* : a physician who is qualified by advanced training and certification by a specialty examining board to so limit his or her practice.” DMS does not view physical therapists, speech-language pathologists, or occupational therapists as meeting this definition.

<http://www.merriam-webster.com/medical/specialist>

Given the direct physician contact requirement in 907 KAR 3:005 and the requirement in the approved state plan amendment to apply all program restrictions/limits to Telehealth, DMS is unable to remove the requirement at this time.

(18) Subject: KRS 194A.125 Regarding Telehealth Network and Technology

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“We also recommend that KRS 194A.125 be amended to address the current Telehealth network and technology. KRS 194A.125 was enacted in 2007 and amended for technical reasons in 2012. Among its functions, the Telehealth Board is to develop a Telehealth network of no more than 25 rural sites and set forth the protocols and standards to be followed. While Saint Joseph Health System, Inc., a member of KentuckyOne Health, Inc., has Kentucky Telehealth Board approval of its network, it is not clear whether each Telehealth site it brings online needs additional approval or whether its newly merged entity Jewish Hospital & St. Mary’s Healthcare, Inc. and its other collaborative partners need separate approval. If KentuckyOne Health, Inc. were to affiliate/collaborate with a health department in its developing community based health delivery model, would this need to be administered by the University of Kentucky or the University of Louisville? KentuckyOne Health, Inc. has developed its own standards and protocols for its own provider services for patients for use in disease management, quality assurance, quality improvement, etc.”

(b) Response: DMS agrees that the statute should be updated; however, DMS lacks the authority to do so as the legislative branch has jurisdiction over Kentucky Revised Statutes.

(c) Comment: Ms. Cull also stated the following:

“We also recommend that KRS 194A.125 be amended to clarify whether the Kentucky Telehealth Network is an open or closed network for private organization participation. KRS 194A.125 describes those who will comprise the Kentucky Telehealth Network Board. Currently, the only opportunity for representation is as an at-large member, which is appointed by the Governor. We propose that membership be expanded to include private organization participation to foster patient care delivery and access to care.”

(d) Response: DMS does not disagree with the comments; however, DMS lacks the authority to amend a Kentucky Revised Statute as the legislative branch has jurisdiction in the matter.

(19) Subject: Publicize Annual Plan/Outcomes

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“The regulation refers to funding rural sites and Telehealth Training Centers. We recommend a requirement for a publicized annual plan for the training centers, and reported outcomes demonstrating how Telehealth has been advocated, supported, and implemented across the Commonwealth to assist existing or new Telehealth consulting or referral sites. This should include a comparative review of other statewide Telehealth programs, for greater understanding of how our state Telehealth network measures against accomplishments achieved and services provided among other states across

the nation. As long as tax dollars support the Kentucky Telehealth Network, associated accountability should be established for the Board, training centers, and other entities to provide transparency, measurable goals and objectives, and open avenues for further public/private collaboration.”

(b) Response: This administrative regulation does not address funding of the rural site or training centers in the Kentucky Telehealth Network; however, a statute (KRS 194A.125) addresses the subject. DMS does not disagree with the recommendation, but it lacks the authority to require the Kentucky Telehealth Network to perform or publish the recommended information.

(20) Subject: Kentucky Telehealth Network

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 8, line 3. The term “Telehealth Provider” as an approved member of the Kentucky Telehealth Network is unclear as to whether individuals who are employed by facilities need to be approved members or whether the entity/facility is the member. Further, a member of the Kentucky Telehealth Network would be presumed to comply with the standards and protocols established by the Kentucky Telehealth Board, which negates the necessity of lines 5 and 6.”

(b) Response: The Telehealth provider is the billing individual/entity; thus, if a given entity is in the Kentucky Telehealth Network, each of the entity’s individual practitioners are not required to be in the Kentucky Telehealth Network.

(c) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“In keeping with the attached September 29, 2008 letter, which states that the Saint Joseph Hospital network is ‘to become a reimbursement-only site on the Kentucky Telehealth Network,’ the regulation should be amended to explain the definition of levels of membership in the Kentucky Telehealth Network. As currently written, the regulation is unclear as to when, or if, a reimbursement-only site becomes a ‘member’ of the Kentucky Telehealth Network. Further clarification is also needed on the definition of membership and membership levels in the Kentucky Health Network.”

(d) Response: DMS shared the comment with Rob Sprang, the Co-Project Manager of the Kentucky Telehealth Network, and Mr. Sprang explained as follows:

“At one time, there were different member levels. Full members received equipment from the initial funding that was provided by the legislation, but most are ‘reimbursement only’ members. These are organizations or individuals who send a letter to the board of directors and are approved by the board.”

DMS is inserting the following language in an “amended after comments” regulation to clarify the requirements related to being an approved member of the Kentucky Telehealth Network:

“(b) To be 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.”

(21) Subject: Lack of Clarity Regarding e-Health Network Board/Telehealth Network

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“The State Plan Amendment Document, TN No.: 09-008 dated March 9, 2011, states: “Eligible Providers: Providers of Telehealth services shall be initially approved by the Kentucky e-Health Network Board.” It is not clear if individual providers are required to become members of the Kentucky Telehealth Network as well as receive approval by the Kentucky e-Health Network Board. It is also unclear whether providers, such as health care systems, in a global sense, are also required to obtain approval from the Kentucky e-Health Network Board.”

(b) Response: The language requiring Kentucky e-Health Network Board approval is a mistake. There is no such requirement.

(22) Subject: Utilization Review

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 8, line 14. This provision regarding utilization review does not explain how the Telehealth consultation is subject to utilization review.”

(b) Response: DMS is inserting the following bold-faced language in an “amended after comments” regulation to address the comment:

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

1. ~~(a)~~ Medical necessity;

2. ~~(b)~~ Compliance with this administrative regulation; and

3. ~~(c)~~ 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.”

(23) Subject: Add Inpatient/Outpatient Hospital/Business Associate of a Health Care System

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 14, line 5 requires a licensed dietitian, certified nutritionist, APRN, Occupational Therapist, Physical Therapist, Speech Therapist to have direct employment by a physician, etc. Wording should include ‘inpatient’ or ‘outpatient department of a hospital,’ or ‘a department or a business associate of a health care system.’”

(b) Response: Regarding the listed practitioners and inpatient hospital settings, DMS reimburses for inpatient hospital care on a diagnosis-related group (DRG) basis or per diem basis depending on the type of hospital rather than on an itemized service-by-service basis as DMS does regarding Telehealth consultations. In the inpatient hospital scenarios, DMS reimburses the hospital for the full array of care provided to the given recipient (again, either via a DRG payment or per diem payment.) The inpatient hospital may pay practitioners as it chooses, but DMS’s reimbursement obligation to the inpatient hospital is satisfied by DMS’s DRG or per diem payment.

Regarding the listed practitioners and outpatient hospital settings, the regulation authorizes physical therapy and speech therapy to be provided via Telehealth in an outpatient hospital setting. It mistakenly also includes occupational therapy; however, DMS does not reimburse for occupational therapy in an outpatient hospital setting. Consequently, DMS is deleting the occupational therapy language associated with outpatient hospital setting from Section 3(2)(i) of the regulation.

DMS is adding, in an “amended after comments” regulation, individual medical nutrition therapy and diabetes self-management as Telehealth consultations provided by licensed dietitians and certified nutritionists in a hospital’s outpatient department.

Regarding the listed practitioners and the term “department or a business associate of a health care system”, the term is too broad. DMS must ensure that its policies regarding Telehealth consultation coverage do not result in DMS reimbursing for services provided via Telehealth that it does not cover in a face-to-face setting or beyond the limits and restrictions established for the respective Medicaid programs. The state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), and through which CMS provides federal funding to DMS for Telehealth consultations, states, “Coverage for services rendered through telehealth service, provided at the originating site, are covered to the same extent the service and the provider are covered when not furnished through telehealth” The approved state plan amendment also

states the following:

“All Telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider’s professional standards.” Additionally, regarding speech-language pathologists, occupational therapists, physical therapists, licensed dietitians, certified nutritionists, registered nurses, and dietitians, the amendment also states “certain restrictions apply for these providers and are outlined in the Kentucky Administrative Regulations”

(24) Subject: Community Mental Health Center Barrier

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 9. The barriers erected by limiting services that can be provided in and out of community mental health centers prohibit the integration of mental and physical health services. In addition, the regulation restricts payment to a psychologist unless the psychologist is employed by a psychiatrist and the psychiatrist interacts with patients during an appointment. The question of medical necessity arises with regard to two professionals providing services, which may be most appropriately rendered by one, as well as which professional will be paid and at what rate. If, for example, there is psychological counseling at a school or counseling by a marriage and family therapist at a clinic or grief counseling in a hospital, both providers must be present to bill under this regulation. The same restrictions apply to licensed professional clinical counselors, licensed clinical social workers, and licensed marriage and family therapists.”

(b) Response: The state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), and through which CMS provides federal funding to DMS for Telehealth consultations, states, “Coverage for services rendered through telehealth service, provided at the originating site, are covered to the same extent the service and the provider are covered when not furnished through telehealth” It also states the following:

“All Telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider’s professional standards.”

DMS’s community mental health center service coverage contains unique policies which differ from other services’ coverage (physicians’ services, outpatient hospital services, for example); thus, DMS is required to differentiate the policies in the administrative regulation.

The approved state plan amendment also establishes the restrictions referred to in the comment regarding certain behavioral health professionals. For example, it lists the following as authorized practitioners:

“A psychologist with a license in accordance with KRS 319.010(5) and a doctorate

degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter.” It establishes the same requirement (directly employed by and psychiatrist/psychiatrist interaction with recipient) for licensed clinical social workers, licensed professional clinical counselors, and licensed marriage and family therapists.

Regarding the billing entity, DMS does not independently enroll licensed psychologists, licensed clinical social workers, licensed professional clinical counselors, or licensed marriage and family therapists. Each of these practitioners must be employed by a psychiatrist (who is the billing entity) or community mental health center (who is the billing entity) and DMS reimburses the psychiatrist or the community mental health center for the care.

DMS reimburses for inpatient hospital care on either a diagnosis-related group (DRG) basis or per diem rate basis. In both scenarios DMS makes a payment to the inpatient hospital that represents total reimbursement for the full array of care provided to the given recipient and does not itemize reimbursement on an individual service-by-service basis segregated by practitioner.

(25) Subject: Electronic Medical Records

(a) Comment: Marie Alagia Cull, on behalf of KentuckyOne Health, Inc., stated the following:

“Page 34-address EMR storage.”

Ms. Cull also stated the following:

“Page 35, Section 8, governing medical records, needs to address an electronic medical record, the content of which is almost simultaneously inserted by the Telehealth consultant in the EMR.”

(b) Response: DMS is inserting language in an “amended after comments” regulation to state that a provider shall have the capability of generating a hard copy record.

(c) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“Language added to ensure the reviewer of the medical record knows that Community Mental Health Centers do not require, as similarly suggested in #5 above, ‘a referral by a health care provider.’”

The above individuals recommended the following amendment (in boldface):

“Section 8.[7.] Medical Records. (1) A request for a telehealth consultation from a health care provider **unless provided in a community mental health center place of service**; and the medical necessity for the telehealth consultation shall be documented in the recipient's medical record.”

(d) Response: Even though the community mental health center can be both a provider and a telehealth consultant, DMS believes it appropriate to document the request for and medical necessity of the consultation in the recipient’s medical record.

(26) Subject: Use of the Term “Consultation” in a CMHC Setting

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“It is suggested the word ‘consultation’ be removed from the Community Mental Health Center section, as ‘consultation’ is not a service currently provided or recognized by the Department for Medicaid Services for reimbursement. It is suggested the language ‘telehealth services’ be inserted.”

Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) also stated the following:

“It is unclear how the word ‘consultation’ is being utilized for a Community Mental Health Center (CMHC). Question: Does ‘consultation’ convey a service allowed and delivered by a CMHC as defined in the Department for Medicaid Services, Community Mental Health Center Services Manual, January 2008 edition? If so, this needs to be made clear and different language particular to CMHCs such as ‘telehealth services’, as ‘consultation’ is not an allowed service via this same manual.”

(b) Response: DMS uses the term “Telehealth consultation” because that is the term used in the Kentucky law (KRS 205.559) which authorizes the Medicaid Telehealth program. KRS 205.559(1) states:

“(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).”

Telehealth consultation is the broad term used to encompass any Telehealth and is defined by KRS 205.510(15) as follows:

“(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;.”

The state plan amendment approved by CMS and through which federal funding is provided for Medicaid’s Telehealth program, also uses the term “consultation.”

The term “consultation” may not be used in specific Medicaid programs, but in the Telehealth context is used broadly to encompass services provided via Telehealth.

(27) Subject: Add Behavioral Health Outpatient Therapy Service and Emergency Behavioral Health Service

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“It is suggested that the regulation allow for two additional services already covered by the Department for Medicaid Services for Community Mental Health Centers: Behavioral Health Outpatient Therapy Service and Emergency Behavioral Health Service. Appropriate providers as defined earlier in added language are currently authorized to deliver the services.”

Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care;

Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) also stated the following:

“Community Mental Health Centers would like to add two additional services covered by the Department for Medicaid Services, in addition to the three covered services currently in the regulation – Behavioral Health Outpatient Therapy Service and Emergency Behavioral Health Service with appropriate providers for which the Department for Medicaid Services reimburses as defined in the Definitions of this regulation and are either defined in the current regulation or were added to this revised regulation through comments contained within, according to each profession’s respective licensure or credential.”

(b) Response: DMS is adding “mental health evaluation and management emergency services” in an “amended after comments” regulation to the types of Telehealth consultations that are covered in a community mental health center. DMS views outpatient therapy as too broad of a term in contrast to the specific language in the approved state plan amendment – “individual psychotherapy” and “group psychotherapy.” As stated previously in this statement of consideration, the current face-to-face requirement (in the community mental health center services program) for individual psychotherapy precludes DMS from being able to add it to the types of covered Telehealth consultations in a community mental health center.

(28) Subject: Reinsert CMHC Services

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“Language that was struck from the regulation submitted to LRC was reinserted to list the services that a Community Mental Health Center provides, and also includes the method in which the services can be delivered.”

Below is the language that the above parties requested be reinserted into the administrative regulation:

“Section 3. Coverage of Telehealth Provided by a Community Mental Health Center.
(1) The department shall reimburse for the following telehealth services provided via a community mental health center provider as defined in the current Department of Medicaid Community Mental Health Center Services Manual.
(a) A psychiatric diagnosis or evaluation interview.
(b) Outpatient individual therapy.

- (c) Inpatient services.
- (d) Collateral services
- (e) Family therapy.
- (f) Group therapy.
- (g) Chemotherapy services.
- (h) Emergency services
- (2) The department shall not reimburse for a telehealth service if the service:
 - (a) Is not medically necessary; or
 - (b) Requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371.
- (3) A telehealth service shall require:
 - (a) The use of two (2) way interactive video.”

(b) Response: The primary purpose of the amended regulation is to make the regulation comport with the policies and requirements represented in the “state plan amendment” (regarding Telehealth consultations) approved by the Centers for Medicare and Medicaid Services (CMS). As background, DMS submitted a state plan amendment which mirrored the current regulation (meaning the current adopted regulation and not the amended version DMS filed with the Legislative Research Commission on October 8, 2012. During CMS’s review of the state plan amendment, CMS noted discrepancies between DMS policies for face-to-face services and the policies stated in the Telehealth state plan amendment. For example, DMS imposed certain limits or restrictions on the amount of services, or did not authorize certain practitioners to provide certain services, or required certain practitioners to be employed by another provider or entity rather than independently provide services. As a result, CMS required that all program restrictions and limits – as stated in DMS’s state plan for services not provide via Telehealth – must also be imposed for the same services being provided via Telehealth.

In preparing the section of this amended regulation which establishes Telehealth requirements in a community mental health center setting, DMS examined the community mental health center requirements (including service limits and restrictions as well as practitioner limits and restrictions.)

Additionally, the approved state plan amendment authorizes the following categories of services in a Telehealth setting:

1. Consultations;
2. Mental health evaluation and management services;
3. Individual and group psychotherapy;
4. Pharmacologic management;
5. Psychiatric/psychological/mental health diagnostic interview examinations;
6. Individual medical nutrition services.

In order to ensure that DMS does not jeopardize federal funding or place itself in a position where it allows a given service to be provided via Telehealth that CMS later (following an audit) determines was not allowable given the approved state plan amendment, DMS must not authorize any service or services beyond the scope of the

approved state plan amendment.

The regulation currently covers psychiatric diagnostic interview examinations and they are listed as covered Telehealth consultations in the approved state plan amendment.

DMS views outpatient individual therapy as too broad of a term in contrast to the specific language in the approved state plan amendment – “individual psychotherapy” and “group psychotherapy.” Additionally, “individual therapy” must be provided “in a face-to-face, one-on-one encounter” according to the Community Mental Health Center Services Manual incorporated by reference into 907 KAR 1:044. One of the requirements of the approved state plan amendment is that “all services are covered to the same extent the service and the provider are covered when not provided through Telehealth.” Additionally, the approved state plan amendment also states, “All telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider’s professional standards.” Given the face-to-face requirement in the Community Mental Health Center Services Manual for individual therapy, DMS cannot authorize “individual therapy” to be covered via Telehealth. For the same reason (a face-to-face requirement stated in the Community Mental Health Center Services Manual) DMS cannot authorize collateral services to be covered if provided via Telehealth.

DMS views inpatient services as a setting rather than a type of service as it could encompass various services and, thus, is too broad in contrast to the approved state plan amendment through which the Centers for Medicare and Medicaid Services provides federal funding to DMS.

The Community Mental Health Center Services Manual incorporated by reference into 907 KAR 1:044, requires collateral services to be provided “face-to-face”; thus, DMS (for the same reasons as stated regarding individual psychotherapy” cannot include collateral services in the covered Telehealth consultations in community mental health centers.

The approved state plan amendment does not include family therapy as a covered Telehealth consultation; therefore, DMS is not adding it to the regulation as a covered Telehealth consultation.

As group psychotherapy is authorized by the approved state plan and has no restriction or limit in the CMHC program which precludes it from being covered if provided via Telehealth, DMS is adding it to the list of covered Telehealth consultations in a CMHC setting in an “amended after comments” regulation.

Chemotherapy services fall under the category of pharmacologic management and, thus, are authorized to be provided via Telehealth.

DMS is also amending the regulation to add “mental health evaluation and management emergency services” to the list of Telehealth consultations covered in a community

mental health center as this fits within the scope of the approved state plan amendment.

Similarly, DMS is adding mental health assessment provided by a licensed psychologist to the list of Telehealth consultations covered in a community mental health center as this fits within the scope of the approved state plan amendment.

(29) Subject: Reimbursement Language in Section 5.

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) referred to the reimbursement language in Section 5 and stated the following:

“This language does not comport with language used on Page 2 and referenced in the attached regulation of suggested changes.”

(b) Response: DMS is clarifying the language in an “amended after comments” by adding the following language:

“A managed care organization shall not be required to reimburse the same amount for a telehealth consultation as the department reimburses, but shall be authorized to reimburse as the department reimburses if it chooses to do so.”

(30) Subject: Written Report

(a) Comment: Rob Sprang, Director of Kentucky TeleCare and Co-Project Manager of the Kentucky TeleHealth Network; Jamie S. Burton, Chief Executive Officer of The Adanta Group Community Mental Health Center; Tony Zipple, Executive Director of Seven Counties Services; Mike Kadish, Interim Executive Director of Kentucky River Community Care; Mots Boshnoi, Executive Director of Mountain Comprehensive Care Center; and Steve Shannon, executive director of the Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc., (KARP) stated the following:

“The regulation states a ‘written report regarding a telehealth consultation . . . [is sent to] the referring health care provider.’ Language ‘as applicable’ was added, as the Community Mental Health Center is the health care provider.”

The above individuals recommended the following amendment (italicized and in boldface):

“(b) A telehealth provider shall send a written report regarding a telehealth consultation within thirty (30) days of the consultation to the referring health care provider ***if***

applicable.

(b) Response: DMS is amending the language in an “amended after comments” regulation as follows:

“(b) **Except as established in paragraph (c) of this subsection,** A telehealth provider 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.”

(31) Subject: Occupational Therapy in an Outpatient Hospital

(a) and (b) Comment and Response: DMS notes that it reimburses for physical therapy and speech therapy, but not occupational therapy, in an outpatient hospital setting; thus, it is deleting the language in Section 3(2)(i) which indicates that DMS will reimburse for occupational therapy provided via Telehealth in an outpatient hospital setting.

(31) Subject: Practitioners as Agents of Providers

(a) Comment: Marie Alagia Cull on behalf of KentuckyOne Health, Inc., stated the following:

“Further, if a practitioner is able to bill Medicaid for services ordered by a physician or, pursuant to the practitioner’s scope of practice, it should not be necessary that the individual be directly employed by any entity if the service is being rendered pursuant to a medically necessary plan of care.”

(b) Response: The primary purpose of the amended regulation is to make the regulation comport with the policies and requirements represented in the “state plan amendment” (regarding Telehealth consultations) approved by the Centers for Medicare and Medicaid Services (CMS). As background, DMS submitted a state plan amendment which mirrored the current regulation (meaning the current adopted regulation and not the amended version DMS filed with the Legislative Research Commission on October 8, 2012. During CMS’s review of the state plan amendment, CMS noted discrepancies between DMS policies for face-to-face services and the policies stated in the Telehealth state plan amendment. For example, DMS imposed certain limits or restrictions on the amount of services, or did not authorize certain practitioners to provide certain services, or required certain practitioners to be employed by another provider or entity rather than independently provide services. As a result, CMS required that all program restrictions and limits – as stated in DMS’s state plan for services not provide via Telehealth – must also be imposed for the same services being provided via Telehealth.

One such example is the employment requirement for practitioners of covered physicians’ program services. For example, the physicians’ services administrative

regulation (907 KAR 3:005) defines other licensed medical professional (which includes some practitioners listed in this administrative regulation) and states the following - Section 3(3):

“(3) A service provided by an individual who meets the definition of other licensed medical professional shall be covered if:

- (a) The individual is employed by the supervising physician;
- (b) The individual is licensed in the state of practice; and
- (c) The supervising physician has direct physician contact with the recipient.”

Also, the approved state plan amendment requires, outside of the community mental health center setting, that behavioral health practitioners be “directly employed by a psychiatrist.”

DMS must ensure that the administrative regulation comports with the approved state plan amendment.

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

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 9:005 and is amending the administrative regulation as follows:

Page 1
Necessity, Function, and Conformity Paragraph
Line 21

After “shall”, insert “also”.

Page 2
Necessity, Function, and Conformity Paragraph
Line 5

After “if”, insert “the managed care organization”.
Delete “it”.

Page 2
Section 1(5)
Lines 14

After “(5)”, delete the following:
“Dentist” is defined by KRS 313.010(10).

Page 2
Section 1(6)
Line 18

Delete "(6)".

Page 2

Section 1(7)

Line 20

Renumber by inserting "(6)" and by deleting "(7)".

After "management", insert "training consultation".

Delete "education".

Page 2

Section 1(8)

Line 22

Renumber by inserting "(7)" and by deleting "(8)".

Page 3

Section 1(9) to (13)

Lines 1, 5, 8, 9, and 14

Renumber these five subsections by inserting "(8)", "(9)", "(10)", "(11)", and "(12)", respectively, and by deleting "(9)", "(10)", "(11)", "(12)", and "(13)", respectively.

Page 3

Section 1(13)(a)

Line 15

After "907 KAR 1:672", insert "and".

Page 3

Section 1(13)(b)

Line 16

After "907 KAR 1:671", insert a period, a return, and "(13)".

Delete "; and".

Page 3

Section 1(13)(c)1.

Lines 17 to 23 to

Page 4

Lines 1 to 5

Delete the following:

- (c)1. Licensed physician;
2. Licensed advanced practice registered nurse;
3. Physician assistant working under a supervising physician;
4. Licensed dentist;
5. Licensed oral surgeon;
6. A psychologist:
 - a. With a license in accordance with KRS 319.010(5); and
 - b. With a doctorate degree in psychology;

7. Licensed clinical social worker;
8. Chiropractor;
9. Licensed optometrist; or
10. Community mental health center.

Page 4

Section 1(14)

Line 16

Delete "(14)".

Page 4

Section 1(15) to (17)

Line 19

Renumber these three subsections by inserting "(14)", "(15)", and "(16)", respectively, and by deleting "(15)", "(16)", and "(17)", respectively.

Page 5

Section 1(16) to (26)

Lines 1, 3, 4, 5, 6, 8, 12, 13, 15, 16, and 17

Renumber these eleven subsections by inserting "(15)", "(16)", "(17)", "(18)", "(19)", "(20)", "(21)", "(22)", "(23)", "(24)", and "(25)", respectively, and by deleting "(16)", "(17)", "(18)", "(19)", "(20)", "(21)", "(22)", "(23)", "(24)", "(25)", and "(26)", respectively.

Page 6

Section 1(27) to (33)

Lines 11, 12, 13, 14, 16, 17, and 21

Renumber these seven subsections by inserting "(26)", "(27)", "(28)", "(29)", "(30)", "(31)", and "(32)", respectively, and by deleting "(27)", "(28)", "(29)", "(30)", "(31)", "(32)", and "(33)", respectively.

Page 7

Section 1(34) to (36)

Lines 2, 4, and 6

Renumber these three subsections by inserting "(33)", "(34)", and "(35)", respectively, and by deleting "(34)", "(35)", and "(36)", respectively.

Page 8

Section 2(2)

Line 3

After "(2)", insert "(a)".

Page 8

Section 2(2)(a)

Line 4

Renumber by inserting "1." and by deleting "(a)".

Page 8
Section 2(2)(b)
Line 5

Re-number by inserting "2." and by deleting "(b)".

Line 6

After "Board.", insert a return and the following:

(b) To be 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.

Page 8
Section 2(4)
Line 14

After "(4)", insert "(a)".

Page 8
Section 2(4)(a) to (c)
Lines 15, 16, and 17

Re-number these three paragraphs by inserting "1.", "2.", and "3.", respectively, and by deleting "(a)", "(b)", and "(c)", respectively.

Page 8
Section 2(4)(c)
Line 17

After "law.", insert a return and the following:

(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.

Page 12
Section 3(2)(c)7.b.(ii)
Line 10

After "licensed", insert "marriage and family therapist".
Delete "dietitian".

Page 12

Section 3(2)(e)7.b.(ii)

Line 3

After "licensed", insert "marriage and family therapist".

Delete "dietitian".

Page 14

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

Line 7

After "primary care center,", insert "a hospital's outpatient department,".

Page 14

Section 3(2)(f)1.b.(i)

Line 9

After "rural health clinic,", insert "hospital's outpatient department,".

Page 14

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

Line 15

After "health clinic,", insert "a hospital's outpatient department,".

Page 14

Section 3(2)(f)2.b.(i)

Line 17

After "rural health clinic,", insert "hospital's outpatient department,".

Page 15

Section 3(2)(g)2.e.

Line 9

After "primary care center,", insert "a hospital's outpatient department,".

Page 15

Section 3(2)(g)3.a.

Line 11

After "rural health clinic,", insert "hospital's outpatient department,".

Page 15

Section 3(2)(i)

Line 21

After "by", insert the following:

or is an agent of a nursing facility

Delete "a hospital's outpatient department".

Page 15

Section 3(2)(i)1.

Line 22

After “under the”, insert “nursing facility’s”.
Delete “hospital’s outpatient department’s”.

Page 16
Section 3(2)(i)2.
Line 1

After “established in”, insert “907 KAR 1:065”.
Delete “907 KAR 10:014”.

Page 16
Section 3(2)(j)
Line 3

After “by”, insert the following:
or is an agent of

Page 16
Section 3(2)(l)
Line 12

After “by”, insert the following:
or is an agent of

Page 16
Section 3(2)(m)
Line 17

After “by”, insert the following:
or is an agent of

Page 16
Section 3(2)(n)
Line 20

After “(n)”, insert the following:
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)

Page 17
Section 3(2)(o)
Line 2

Renumber this paragraph by inserting “(p)”, and by deleting “(o)”.

Line 3
After “by”, insert the following:
or is an agent of

Page 17
Section 3(2)(p)
Line 7

Renumber this paragraph by inserting “(q)”, and by deleting “(p)”.

Line 8
After “by”, insert the following:
or is an agent of

Page 17
Section 3(2)(p)2.
Line 10

After “907 KAR 1:030;”, insert a return and the following:
(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)

Page 17
Section 3(2)(q)
Line 11

Delete “(q)”.

Page 17
Section 3(2)(r)
Line 23

Renumber by inserting “(t)” and by deleting “(r)”.

Page 18
Section 4(3)(b)
Line 21

After “not”, insert the following:

“
1.”

After “center”, insert the following:

; or
2. An agent of a community mental health center

Page 19
Section 4(4)(b)2.b.(ii)
Line 15

After “psychology;”, delete “or”.

Page 19

Section 4(4)(c)2.c.(ii)

Line 23

Renumber by inserting “(ii)” and by deleting “(lii)”.

After “907 KAR 20:057”, insert a semi-colon, a return and the following:

(d) Group psychotherapy provided:

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

2. By:

a. A psychiatrist;

b. A psychologist:

(i) With a license in accordance with KRS 319.010(5); and

(ii) With a doctorate degree in psychology;

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

lii) 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:

(i) With a license in accordance with KRS 319.010(5); and

(ii) With a doctorate degree in psychology;

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

lii) Meets the requirements established in 201 KAR 20:057; or

(f) A mental health assessment provided:

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

2. By a psychologist:

a. With a license in accordance with KRS 319.010(5); and

b. With a doctorate degree in psychology

Page 32

Section 5(1)

Line 18

After “(1)”, insert “(a)”.

After “provider”, insert a return and the following:

who is eligible for reimbursement from the department, is currently enrolled as a provider in accordance with 907 KAR 1:672, and currently participating in the Medicaid program in accordance with 907 KAR 1:671

Page 32

Section 5(1)(a) and (b)

Lines 20 and 23

Renumber these two paragraphs by inserting “1.” and “2.”, respectively, and by deleting “(a)” and “(b)”, respectively.

Page 33

Section 5(1)(c)

Line 1

Renumber this paragraph by inserting “3.” and deleting “(c)”.

Line 2

After “907 KAR 1:104.”, insert a return and the following:

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

Page 35

Section 8(3)

Line 13

After “(3)”, insert “(a)”.

Line 14

After “45 C.F.R. 164.530(j).”, insert a return and the following:

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

Page 36

Section 8(5)(b)

Line 6

After “(b)”, insert the following:

Except as established in paragraph (c) of this subsection,

Line 7

After “provider.”, insert the following:

(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.