

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: No limitations With limitations*
- 2.a. Outpatient hospital services.
Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).
 Provided: No limitations With limitations*
 Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
Provided: No limitations With limitations*

*Description provided on attachment.

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HCFA ID: 7986E

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

- 4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: No limitations With limitations*

- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations*

- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations With limitations*

5. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Podiatrists' services.

Provided: No limitations With limitations*

* Description provided on attachment.

TN No. 92-14
Supersedes 93-9 Approval Date 8/2/94 Effective Date 6/1/94
TR No. 93-9

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Commonwealth Global Choices

b. Optometrists' services.

X Provided: No limitations X With limitations* Not Provided.

c. Chiropractors' services.

X Provided: No limitations X With limitations* Not provided.

d. Other Practitioners' Services

X Provided: No limitations X With limitations* Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

X Provided: No limitations X With Limitations* Not provided.

b. Home health aide services provided by a home health agency.

X Provided: No limitations X With limitations* Not provided.

c. Medical supplies suitable for use in the home.

X Provided: No limitations X With limitations* Not provided.

*Description provided on attachment.

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TN No.: 03-006

Implementation Date: 05/15/06

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*
 Not provided.

8. Private duty nursing services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. 92-1
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TN No. None

HCFA ID: 7985E

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

Provided: No limitations With limitations*
 Not provided.

10. Dental services.

Provided: No limitations With limitations*
 Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations*
 Not provided.

b. Occupational therapy.

Provided: No limitations With limitations*
 Not provided.

c. Services for individuals with speech, hearing, and language disorders
(provided by or under the supervision of a speech pathologist or
audiologist).

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

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HCFA ID: 0069P/0002P

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed drugs

- Provided. No limitations With limitations*
 Not provided

b. Dentures

- Provided No limitations With limitations*
 Not provided

c. Prosthetic devices

- Provided. No limitations With limitations*
 Not provided.

d. Eyeglasses

- Provided. No limitations With limitations*
 Not provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services

- Provided. No limitations With limitations*
 Not provided.

*Description provided in attachment

AMOUNT, DURATION AND SCOPE OF MEDICAL
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b. Screening services.

Provided: No limitations With limitations*
 Not provided.

c. Preventive services.

Provided: No limitations With limitations*
 Not provided.

d. Rehabilitative services.

Provided: No limitations With limitations*
 Not provided.

14. Services for individuals age 45 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided: No limitations With limitations*
 Not provided.

b. Nursing facility services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
Services-in an Intermediate Care Facility for the Mentally
Retarded

15. a. ~~Nursing facility services~~ (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

Provided: No limitations With limitations*

Not provided.

- b. ~~Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.~~

~~Provided: No limitations With limitations*~~

~~Not provided.~~

ef. 11/1/90

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided: No limitations With limitations*

Not provided.

17. Nurse-midwife services.

Provided: No limitations With limitations*

Not provided.

18. Hospice care (in accordance with section 1905(c) of the Act).

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

TR No. 90-37
Supersedes
TR No. 90-32

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↳ Inpatient Hospital Services

- a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program; this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing.
- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.
- c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
- (a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
 - (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/candylomas, anterior nose bleeds, and cervix
 - (c) Circumcision.
 - (d) Dilation: dilatation and curettage (diagnostic or therapeutic non-obstetrical); dilatation/probing of lacrimal duct
 - (e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
 - (f) Exam under anesthesia (pelvic).

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- g) Excision: Bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - h) Extraction: foreign body, and teeth (per existing policy).
 - i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - j) Hymenotomy.
 - k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision
 - m) Myringotomy with or without tubes, otoplasty.
 - n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosigmoidoscopy.
 - o) Removal: ILLD, and fingernail or toenails.
 - p) Tenotomy hand or foot.
 - q) Vasectomy.
 - r) Z-plasty for relaxation of scar/contracture.
- d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

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documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

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3. Other Lab and X-Ray Services

A. Coverage.

- (1) The department shall reimburse for a procedure provided by an independent laboratory if the procedure:
- (a) Is one that the laboratory is certified to provide by Medicare and in accordance with state regulation.
 - (b) Is a covered service within the CPT code range of 80047 – 89356 except as indicated in Section B.
 - (c) Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and
 - (d) Is supervised by a laboratory director; and
 - (e) Is independent of an institutional setting
- (2) The department shall reimburse for a radiological service if the service:
- (a) Is provided by a facility that:
 - 1) Is licensed to provide radiological services;
 - 2) Meets the requirements established in 42 CFR 440.30;
 - 3) Is certified by Medicare to provide the given service;
 - 4) Meets the requirements established in 42 CFR 493 regarding laboratory certification, registration, or other accreditation as appropriate; and
 - (b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;
 - (c) Is provided under the direction or supervision of a licensed physician; and
 - (d) Is a covered service within the CPT code range of 70010 – 78999.

B. Exclusions. The department shall not reimburse for an independent laboratory or radiological service for the following services or procedures:

- (1) A procedure or service with a CPT code of 88300 through 88399;
- (2) A procedure or service with a CPT code of 89250 through 89356;
- (3) A service provided to a resident of a nursing facility or an intermediate care facility for individuals with mental retardation or a developmental disability; or
- (4) A court-ordered laboratory or toxicology test. The court-ordered exclusion does not apply when medically necessary and in the scope of the Medicaid program.

C. Provider Participation Conditions

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- (1) To be reimbursed by the department for a service provided in accordance with this administrative regulation, a provider of independent laboratory services or radiological services shall:
- (a) Be a Medicaid-enrolled provider;
 - (b) Be a Medicare participating facility;
 - (c) Comply with state regulations on Non-duplication of Payments and Claims processing;
 - (d) Comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1324d-8 and 45 C.F.R. parts 160 and 164; and
 - (e) Annually submit documentation of:
 - 1) Current CLIA certification to the department if the provider is an independent laboratory; and
 - 2) A current radiological license to the department if the provider provides radiological services.
- (2) A provider may bill a recipient for a service not covered by the department if the provider informed the recipient of noncoverage prior to providing the service.

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Diseases) for Individuals 21 Years of Age or Older

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity of the EPSDT services on a case by case basis through prior authorization.

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(1) Out of Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(2) In Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(3) Oral Surgery Dental Services

A listing of oral surgery dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

Commonwealth Global Choices**B. Hearing Services****(1) Audiological Benefits**

(a) Coverage is available only for recipients under age 21 and is limited to the following services provided by certified audiologists:

- i.** Complete hearing evaluation one time per year;
- ii.** Hearing aid evaluation one time per year;
- iii.** A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid such visits to be related to the proper fit and adjustment of that hearing aid; and
- iv.** One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

(b) Services not listed above will be provided when medically necessary upon appropriate pre-authorization through the EPSDT Program.

Commonwealth Global Choices

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

(a) Coverage is provided only for recipients under age 21 on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(2) of the Social Security Act.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(2) of the Social Security Act.

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4 b EPSDT Services (continued)

- D Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn, a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services, a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required.

Neonatal Related Diagnoses

- (1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
- (2) Fetus or newborn affected by maternal complications of pregnancy.
- (3) Fetus or newborn affected by complications of placenta, cord, and membranes.
- (4) Fetus or newborn affected by other complications of labor and delivery.
- (5) Slow fetal growth and fetal malnutrition.
- (6) Disorders relating to short gestation and unspecified low birthweight.
- (7) Disorders relating to long gestation and high birthweight.
- (8) Birth Trauma.
- (9) Intrauterine hypoxia and birth asphyxia.
- (10) Respiratory distress syndrome.
- (11) Other respiratory conditions of fetus and newborn.
- (12) Infections specific to the perinatal period.
- (13) Fetal and neonatal hemorrhage.
- (14) Hemolytic disease of fetus or newborn, due to isoimmunization.
- (15) Other perinatal jaundice.
- (16) Endocrine and metabolic disturbances specific to the fetus and newborn.
- (17) Hematological disorders of fetus and newborn.
- (18) Perinatal disorders of digestive system.
- (19) Conditions involving the integument and temperature regulation of fetus and newborn.
- (20) Congenital anomalies and related surgical procedures.
- (21) Other and ill-defined conditions originating in the perinatal period.

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4.b. Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found.

E. Medicaid Services Provided in Schools

Individuals receiving Medicaid Services in schools have freedom of choice of qualified licensed providers as established in 1902(a)(23) of the Act.

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response.

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, muscle-skeletal assessment, gross motor assessment, and functional mobility assessment.

Treatment services:

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic devices, manual therapy techniques, sensorimotor training, functional mobility training, perceptual motor training.

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Supersedes

TN. No. None

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Eff. Date: 09/15/08

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist. Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Behavioral Health Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor

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Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as follows:

1. An individual currently licensed by the Kentucky Board of Examiners of Psychology as a licensed psychologist, licensed psychological practitioner, certified psychologist with autonomous functioning, certified psychologist, or licensed psychological associate;
2. A licensed clinical social worker currently licensed by the Kentucky Board of Social Work;
3. A licensed social worker currently licensed by the Kentucky Board of Social Work;
4. A certified social worker currently licensed by the Kentucky Board of Social Work;
5. An advanced registered nurse practitioner who has a specialty area in accordance with the American Nurses' Association Statement on Psychiatric Mental Health Clinical Nursing Practice and Standards of Psychiatric Mental Health Clinical Nursing Practice.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan.

Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report: Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers

Treatment services may be performed by a Speech/Language Pathologist with the following qualifications:

1. Current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA);
2. Current license as Speech Language Pathologist from KY Board of Speech Language Pathology and Audiology;

As of August 1, 2011, Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a Speech Language Pathologist with a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).

(f) Nursing Services:

Services must be medically necessary. The services may be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner's written order. The plan of care must be developed by a licensed registered nurse. Services include but are not limited to: assessments including referrals based on results, bladder catheterizations, suctioning, medication administration and management including observation for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:

The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of Kentucky to provide the services and practice within the Kentucky Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act and the Kentucky School Health Program Manual to individuals trained to perform delegated acts by a Registered Nurse.

Services provided by a health aide may only be provided under the following conditions:

1. Is under the supervision of an advanced registered nurse practitioner or a registered nurse;
2. Has been trained by an advanced registered nurse practitioner or registered nurse for the specific nursing service provided to a specific recipient; or
3. An advanced registered nurse practitioner or registered nurse has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

(g) Respiratory Therapy Services:

Respiratory therapy are the procedures employed in the therapy, management, rehabilitation, gathering of assessment information, or other procedures administered to patients with deficiencies or abnormalities which affect their cardiopulmonary system and associated aspects of cardiopulmonary and other systems functions.

Respiratory therapy services are provided by a practitioner certified by the Kentucky Board of Respiratory Care. Incidental interpreter services provided in conjunction with another covered service. These services will be provided based on state law requirements for appropriate specialties. Incidental interpreter services are provided by an interpreter licensed by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing.

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- (h) **Orientation and Mobility Services:** Orientation and mobility services provide sequential instruction to individuals with visual impairment in the use of their remaining senses to determine their position within the environment and in techniques for safe movement from one place to another. The skills in this instruction include but are not limited to concept development, motor development and sensory development.

Orientation and mobility services are provided by an orientation and mobility specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or National Blindness Professional Certification Board (NBPCB).

- (j) **Specialized Transportation Services:** Services must be medically necessary and appear in the child's Individualized Education Plan or an Individual Family Service Plan. Specialized transportation services include transportation to receive Medicaid approved school health services pursuant to an IEP. This service is limited to transportation of covered, prior authorized services.
- 1) The special transportation is Medicaid reimbursable if:
 - (a) It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Kentucky.
 - (b) It is being provided on a day when the child receives a prior authorized covered service;
 - (c) The student's need for specialized transportation service is documented in the child's plan of care; and
 - (d) The driver has a valid driver's license.
 - 2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized health related services.
 - (a) Transportation provided by or under contract with the school, to and from the student's place of residence, to the school where the student receives one of the health related services covered by Title XIX;
 - (b) Transportation provided by or under contract with the school, to and from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or
 - (c) Transportation provided by (or under contract with the school) from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school.
 - 3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

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4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

5. Physicians' Services

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99214 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only, which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

- E. A patient "locked in" to one physician due to over utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.
- F. The cost of preparations used in injections is not considered a covered benefit, except for the following:
- (1) The Rhogam injection.
 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
 - (3) Depo Provera provided in the physician office setting.
 - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
 - (5) Long acting injectable risperidone.
 - (6) An injectable, infused or inhaled drug or biological that is:
 - a. Not typically self-administered,
 - b. Not listed as a noncovered immunization or vaccine; and
 - c. Requires special handling, storage, shipping, dosing or administration.
- G. Coverage for standard transmittance test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- H. Telephone contact between a physician and patient is not a covered service.
- I. Coverage of a physician service is contingent upon direct physician and patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

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- J. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed.
- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material in file in the state agency.

State Kentucky

b. Medical care and any other type of Remedial Care

- a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

- (1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.
- (2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of Flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

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cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarrasment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:
 1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious anemia;
 2. *Associated with carcinoma;
 3. *Associated with diabetes mellitus;
 4. *Associated with drugs and toxins;
 5. *Associated with multiple sclerosis;
 6. *Associated with uremia (chronic renal disease);
 7. Associated with traumatic injury;
 8. Associated with lupus or neurosyphilis; and
 9. Associated with hereditary disorders, such as: hereditary sensory radicular neuropathy, angiodermatoma corporis; and diffusum (Fabry's), amyloid neuropathy.

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Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

- (3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occlusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

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Commonwealth Global Choices

(6) Medical care and Any Other Type of Remedial Care

(b) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

- 1) Eyeglasses are provided only to recipients under age twenty-one (21). Coverage for eyeglasses is limited to no more than \$200 per year per member.
- 2) Contact lenses are not covered.
- 3) Telephone contacts are not covered.
- 4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
- 5) If medically necessary, prism shall be added within the cost of the lenses.

If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

(c) Chiropractic services are provided with the following limitations:

- 1) Fifteen (15) chiropractic visits per year for recipients age 21 and older.
- 2) Seven (7) chiropractic visits per year for recipients under 21 years of age.
- 3) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905(r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

- (1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.
- (2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.
- (3) An ARNP desiring to participate in the Medical Assistance Program shall:
 - (a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
 - (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
 - (c) Accompany each participation application with a current copy of the ARNP's license; and
 - (d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.
- (4) Administration of anesthesia by an ARNP is a covered service.
- (5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
 - a. Rho (D) immune globulin injection;
 - b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Basic Drug Bulletin, as adopted by Medicare;
 - c. Depo-Provera contraceptive injection;
 - d. Penicillin G and ceftriaxone injectable antibiotics; and
 - e. Epidural injections administered for pain control.
- (6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

- (7) An obstetrical and gynecological service provided by an ARNP shall be covered as follows:
- a. An annual gynecological examination;
 - b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
 - c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
 - d. Prenatal care;
 - e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
 - f. A delivery service, which shall include:
 1. Admission to the hospital;
 2. Admission history;
 3. Physical examination;
 4. Anesthesia;
 5. Management of uncomplicated labor;
 6. Vaginal delivery, and
 7. Postpartum care.
- (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
- (9) A limitation on a service provided by a physician as described in Attachment 3.1-A, pages 7.21, 7.21(a) and 7.21(a)(6) shall also apply if the service is provided by an ARNP.
- (10) The same service provided by an ARNP and a physician on the same day within a common practice shall be considered as one (1) covered service.

Commonwealth Global Choices

Other Licensed Practitioners' Services (continued)

- (d) Ophthalmic dispensers' services, limited to dispensing services or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:
 - (1) Telephone contacts are not covered;
 - (2) Contact lens are not covered;
 - (3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

- (e) Pharmacist - Administration of the H1N1 vaccine by a pharmacist who is employed by a pharmacy participating in the Kentucky Medicaid Program.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place or residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies Suitable for Use in the Home.

Each provider desiring to participate as a medical supply provider must be a participating Medicare Provider and sign a provider agreement with the Department for Medicaid Services.

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1. The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity.
 2. Coverage of medical supplies for use by patients in the home, are based on medical necessity.

Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
 - a. Provided in accordance with 42 CFR 440.230;
 - b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability or other medical condition;
 - c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
 - d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver or the provider;
 - e. Provided in the recipient's residence, in accordance with generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
 - f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent lay person standard; and,
 - g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements for recipients under twenty-one (21) years of age.
4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary and reasonable.

COMMONWEALTH GLOBAL CHOICES**7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility**

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

Occupational therapy and physical therapy are limited to fifteen visits per twelve months. Speech pathology services and speech/hearing/language therapy are limited to ten visits per twelve months.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

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9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. **Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.**
2. **Family planning clinics.**
3. **Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.**
4. **Out-patient surgical clinics.**
5. **Other clinics authorized under 42 CFR 440.90.**

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5a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and
2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

13. **Dental Services**

A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency.

B. **Out-of-Hospital Dental Services**

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.

C. **In-Hospital Care**

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.

D. **Oral Surgery**

A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.

COMMONWEALTH GLOBAL CHOICES

11. Physical Therapy and Related Services

A. Physical Therapy

Coverage is limited to:

- (1) The provision of such services when provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities for individuals with mental retardation or developmental disabilities as part of an approved plan of treatment; or
- (2) The provision of such services when provided through participating home health agencies or hospital outpatient departments; and
- (3) Fifteen visits per twelve months.

B. Occupational Therapy

Coverage is limited to:

- (1) The provision of such services through a participating home health agency or when provided to patients in skilled nursing facilities or intermediate care facilities for individuals with mental retardation or developmental disabilities as part of an approved plan of treatment.
- (2) Fifteen visits per twelve months.

C. Services, Including Speech, Hearing and Language Therapy, for Individuals with Speech, Hearing and Language Disorders Provided by or under Supervision of a Speech Pathologist or Audiologist

(1) Speech Disorders

Coverage is limited to:

- (1) The provision of such services when provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities for individuals with mental retardation or developmental disabilities; or
- (2) The provision of such services when provided through participating home health agencies or in hospital outpatient departments; and
- (3) Ten visits per twelve months.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

If medical necessity is established, limitations in this section do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

a. Prescribed Drugs

- (1) Coverage is provided for drugs included in the Medicaid Drug List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant or advanced registered nurse practitioner. Drugs that are on the Preferred Drug List are specified in the Medicaid Drug List. Drugs added to the Preferred Drug List are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Secretary of the Cabinet for Health and Family Services for approval. Drugs not on the Preferred Drug List are subject to the prior authorization process as listed below. Drugs that require prior authorization are specified in the Medicaid Drug List. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.
- (2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The State has established a preferred drug list with prior authorization for drugs not included on the preferred drug list. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1927(d)(4) of the Social Security Act.
- (3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid Drug List or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:
 - (a) A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar" to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;

- (c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement, in accordance with 42 USC 1396r-3(g) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payments for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;
- (d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;
- (e) A drug used to treat sexual or erectile dysfunction, unless the drug is FDA approved to treat a condition other than sexual or erectile dysfunction. (This provision is effective 01/01/2016); and
- (f) A drug dispensed as part of, or incidental and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.
- (4) A patient "checked-in" to one pharmacy due to over-utilization may receive pharmacy services only from Fisher link-in provider except in the case of an emergency or by referral.
- (5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a noncontrolled substance may be refilled up to 11 times within 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug shall be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services shall not be subject to the 92-day supply requirement.
- (6) Kentucky will cover no more than a total of four (4) prescriptions, of which no more than three (3) shall be brand name prescriptions, per recipient per month. If a physician provides sufficient information that a medical need exists for a Medicaid member to receive more than four prescriptions or more than three brand name drug prescriptions in a one-month period, an exception to the four-script limit or three brand allowance will be allowed.
- (7) A refill of a prescription shall not be covered unless at least 30 percent of the prescription time period has elapsed. However, a refill may be covered before 30 percent of the prescription time period has elapsed if the prescribing provider submits a prior authorization request for override consideration.
- (8) Supplemental Rebate Program:
The state is in compliance with Section 1921 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:
- (a) CMS has authorized the Commonwealth of Kentucky to enter into the Michigan Multi-state pooling agreement (MMoPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on January 6, 2015 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on March 11, 2015 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

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- (b) CMS has authorized Kentucky's collection of supplemental rebates through the MMSPA.
 - (c) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.
 - (d) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
 - (e) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
 - (f) As specified in Section 1927(b)(3)(D) of the Act, not withstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.
- (9) Behavioral Pharmacy Management Program
- (a) CMS has authorized the state of Kentucky to enter into a contract with Comprehensive NeuroScience, Inc. (CNS), and Eli Lilly and Company (Lilly). This contract, titled "Agreement By and Among Kentucky Department for Medicaid Services, Comprehensive NeuroScience, Inc., and Eli Lilly and Company," was submitted to CMS September 5, 2006.
 - (b) Under the Agreement, Lilly will forward funds to CNS to set up and conduct a two-year Behavioral Pharmacy Management Program for the Medicaid fee for service program. CNS will utilize data to identify use of behavioral drugs that are not in line with best practices and consult with the provider. This funding will be considered in lieu of a supplemental rate and be considered as such in Kentucky's economic evaluation of the atypical antipsychotic therapeutic class for Preferred Drug List consideration. Kentucky will accept CNS services in lieu of the supplemental rebate. Kentucky will also provide data to CNS only for the purposes of these services.
 - (c) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
 - (d) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
 - (e) As specified in section 1927(b)(3)(D) of the Act, not withstanding any other provision of law, rebate information disclosed by a manufacturer shall not be disclosed by the State for purposes other than rebate invoicing and verification.

Commonwealth Global Choices

h. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the Early, Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 13.

d. Eyeglasses

Eyeglasses are not covered for adults. Eyeglasses are provided only to recipients under age twenty-one (21). Coverage for eyeglasses is limited to no more than \$200 per year per member. If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905(r)(5) of the Social Security Act.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

Diagnostic, screening, preventive, and rehabilitative services are covered only when provided by mental health centers, primary care centers, and other qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

- (1) Attachment 3.1-A, page 5 and 6, item 13. a., b., c., and d., states that diagnostic services, screening services, preventive services, and rehabilitative services (other than those provided elsewhere in the plan) are provided with limitations that are described on this attachment.
- (2) Other mental health services provided outside of mental health centers are limited to those described elsewhere in this plan.
- (3) All covered preventive services are described under other sections of this plan. Specifically, physicians services are described in Attachment 3.1-A, page 7.2.1 through 7.2.1(a)(o) and Attachment 3.1-B, pages 21, 22, and 22.1(a); primary care services are described in Attachment 3.1 A, Page 7.1.1 and Attachment 3.1-B, Page 13.3; rural health center services are described in Attachment 3.1-A, page 7.1.1(b) and Attachment 3.1-B, pages 13.2 and 13.3; ARNP services are described in Attachment 3.1-A, pages 7.2.1(c) and 7.2.1(d) and Attachment 3.1-B, pages 23.1 and 23.2; and EPSDT screening services are described in Attachment 3.1-A, pages 7.1.2 - 7.1.4, 7.1.7, 7.1.8 and Attachment 3.1-B, pages 16 - 18, 20.1, and 20.2.
- (4) Covered services shall be provided by a:
 - (a) Physician;
 - (b) Physician Assistant;
 - (c) Advanced Registered Nurse Practitioner; or
 - (d) Registered Nurse. A "registered nurse" is defined by state law as a person who is licensed in accordance with state law to engage in registered nursing practice. State law defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:

continued to page 7.6.1 (c)

13. d. Community mental health centers provide a comprehensive range of coordinated mental health rehabilitation services. Reimbursement is available for rehabilitation services provided by community mental health centers subject to the following:

- A. Covered mental health rehabilitation services include:
1. Outpatient mental health services. Outpatient mental health services are mental health services that are provided to individuals, families, or groups of persons who are living in the community and require services on an intermittent basis for mental health conditions. The mental health rehabilitation services include diagnostic assessments, individual therapy, group therapy, family therapy, collateral therapy (for individuals under 21), therapeutic rehabilitation services, physical examinations, medication management therapy, and emergency/crisis intervention. Services are provided in accordance with a plan of treatment and may be provided in the recipient's home, work place, mental health facility, personal care home, emergency room or wherever urgently needed.
 2. Inpatient mental health services. Inpatient mental health services are professional psychiatric services provided to a person in a local acute care hospital contracting with a community mental health center to provide such professional psychiatric services.
- B. Medicaid will reimburse for community mental health rehabilitation services when provided to persons diagnosed with a mental health disorder when provided by qualified mental health professionals. The following limitations and conditions will apply:
1. Group therapy is limited to groups of twelve or fewer.
 2. Individual therapy is limited to a maximum of three (3) hours a day.
 3. Substance abuse services are only provided to pregnant and postpartum women.
 4. Unless a diagnosis is made and documented in the medical record within three (3) visits, the service will not be covered.
 5. An appropriate mental health diagnosis is required for coverage.
- C. Professionals qualified to provide mental health rehabilitation services include:
1. A board certified or board eligible psychiatrist.
 2. A licensed psychologist.
 3. A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
 - a. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - b. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.

-
- c. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - d. A graduate of a two-year educational program (Associate Degree) with 3 years of experience in a mental health setting.
 4. A psychiatric social worker with a masters degree from an accredited school.
 5. A professional equivalent, through education in a mental health field and experience in a mental health setting, qualified to provide mental health services. Education and experience are as follows:
 - a. Bachelor's degree and 3 years of full-time supervised experience.
 - b. Master's degree and 6 months of full-time supervised experience.
 - c. Doctoral degree. No experience.
 6. The following professionals may provide services with appropriate supervision:
 - a. A mental health associate with a minimum of a Bachelors degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - b. A certified psychologist or certified psychological practitioner under supervision of a licensed psychologist; and
 - c. A physician under the supervision of a psychiatrist.

13. continued

(I) The care, counsel, and health teaching of the ill, injured, or infirm;
(II) The maintenance of health or prevention of illness of others;
(III) The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:
(i) Preparing and giving medications in the prescribed dosage, route, and frequency, including dispensing medications;
(ii) Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
(iii) Intervening when emergency care is required as a result of drug therapy;
(iv) Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
(v) Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
(vi) Instructing an individual regarding medications;
(IV) The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
(V) The performance of other nursing acts which are authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

(5) Covered services include:

(A) Early and Periodic screening, diagnosis, and treatment (EPSDT): EPSDT services are described in Attachment 3.1-A, pages 7.1.2 - 7.1.4, 7.1.7, 7.1.8, and Attachment 3.1-B, pages 16-18, 20.1, and 20.2.

(B) Pediatric services:

Services include the following:

- (a) Diagnostic and nursing evaluation and management services;
- (b) Provision of all childhood immunizations as described by page 9a of this plan included in the Vaccines for Children program. Provision of other immunizations to children as recommended by the CDC;

13. continued

- (c) Medications and other treatment procedures; and
- (d) Follow-up nursing care.

(C) Prenatal and related services:

Services provided or arranged in accordance with the standards developed for the prenatal program include the following:

- (a) Pregnancy testing/confirmation;
- (b) Contact visit counseling;
- (c) Initial examination;
- (d) Subsequent monitoring visits;
- (e) Laboratory tests, as necessary;
- (f) Individual counseling;
- (g) Hands voluntary home visitation program;
- (h) Initial infant assessment;
- (i) Postpartum visit; and
- (j) Family planning visit.

(D) Communicable disease services:

Communicable disease services include:

- (a) Diagnostic evaluation and management services;
- (b) Laboratory tests, as necessary;
- (c) Medications and other treatment procedures;
- (d) Individual counseling; and
- (e) Adult immunizations as recommended by the CDC

(E) Chronic disease services:

Services are provided for the following:

- (a) Diabetes;
- (b) Heart disease and stroke program;
- (c) Women's Cancer Screening program;
- (d) Substance abuse prevention program;
- (e) Tobacco prevention and cessation;
- (f) Obesity;
- (g) Arthritis/osteoarthritis;
- (h) Depression;
- (i) Oncology;
- (j) Hemophilia;
- (k) Sickle Cell;
- (l) Organ transplants; and
- (m) Rare disease.

13. continued

(F) Family planning services:

Family planning services are described in Attachment 3.1-A, page 7.1.9 and Attachment 3.1-B, page 20.3.

Services include the following:

- (a) Complete medical history;
- (b) Physical examination;
- (c) Laboratory and clinical test supplies; and
- (d) Counseling and prescribed birth control methods to best suit the patient's needs.

Services provided within these categories are those defined by procedure code under the Medicare Physician Fee Schedule.

14.b. Nursing Facility Services for Individuals Age 65 or Older in
and Institutions for Mental Diseases.

C.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray oxygen and oxygen supplies, and ventilator use.

State: Kentucky

15.a. **Services in an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (Other Than Such Services in an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a) (31) (A) of the Act, to be in Need of Such Care**

Program benefits are limited to eligible recipients who require active treatment. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care reveals that the patient no longer requires skilled, nursing facility level of care, or intermediate care for the mentally retarded and developmentally-disabled services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

State KentuckyAttachment 3.1-A
Page 7.8.3

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

- (1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CM ~~(except as further excluded in item 3, below)~~ ^{9.4-91} (P&I-HCFA). Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals.
- (2) Services may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

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Supersedes

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20.b. Rehabilitative Services for Pregnant Woman

The following substance abuse services are covered for pregnant and postpartum women for a sixty-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls for treatment of a substance related disorder, excluding nicotine dependence.

- (1) Substance abuse assessment. An assessment is to include the presenting problem, substance abuse diagnosis (if identified) and the development of an initial plan of care.
- (2) Prevention Services. The prevention services are designed to reduce the risk that an individual will initiate or continue using alcohol, tobacco, and other drugs during pregnancy and the postpartum period. Services will be delivered through approved protocols that may include pre-test and post test surveys, videos with discussion guides, motivational interviewing, participant workbooks, and supportive therapeutic interventions. Services are provided with a face-to-face contact between an individual and a qualified provider, on an outpatient basis and may be delivered in an individual or group setting. Individuals are provided the following services based upon their needs:
 - (a) Universal prevention service.
 1. Targeted audience: Includes members of the population that exhibits no characteristics or behaviors that place them at greater risk of developing alcohol or drug problems or substance dependence.
 2. Goals and objectives:
 - a. Continued or increased perceptions of potential harm to the fetus as a result of using alcohol, tobacco or other drugs during pregnancy.
 - b. Continued or increased intentions to not use alcohol, tobacco and other drugs during pregnancy and lactation; and
 - c. Increased ability to recognize signs of postpartum depression and risk for substance abuse following pregnancy.
 3. Service limitation: A substance abuse universal prevention service shall be provided in ¼ hour increments, not to exceed a total of two (2) hours.
 - (b) Selective prevention service.
 1. Targeted audience: Includes members of the population that have been identified as having a greater incidence of problems associated with their use and/or higher incidences of developing chemical dependence (i.e. Children of Alcoholics, survivors of sexual abuse or domestic violence).
 2. Goals and objectives:
 - a. Abstinence from alcohol, tobacco and other drugs during pregnancy and lactation.
 - b. Increased commitment to not use during pregnancy and lactation;
 - c. Continued or increased perceptions of potential harm to a fetus when alcohol, tobacco or other drugs are used;
 - d. Increased awareness of personal vulnerability to alcohol or drug dependency or other problems throughout life;
 - e. Attitude changes which support an individual in making low risk choices related to tobacco, alcohol and other drug use during and following pregnancy, and
 - f. Developing skills necessary to make and maintain low risk alcohol and other drug choices throughout life.
 3. Service limitation. A selective prevention service shall be provided in ¼ hour increments, not to exceed a total of nineteen (19) hours.

20.b. Rehabilitative Services for Pregnant Woman (continued)**(c) Indicated prevention service**

1. **Targeted audience:** Includes members of the population that do not have a diagnosis of substance abuse or dependency, but do report actually experiencing some problems related to their use of alcohol and drugs.
2. **Goals and objectives:**
 - a. Decreased alcohol and other drug use;
 - b. Attitude changes which support an individual in making low risk choices related to alcohol and other drug use;
 - c. A greater readiness for and response to treatment for an individual with a substance abuse related diagnosis who is receiving this service as an adjunct to a substance abuse treatment plan; and
 - d. Increased skills necessary to make and maintain low risk alcohol and other drug use choices during pregnancy and throughout life.
3. **Service limitation:** An indicated prevention service shall be provided in ¼ hour increments, not to exceed a total of twenty-seven (27) hours.

(c) Qualifications of providers. All of the prevention services are provided by a Kentucky certified preventionist or a Qualified Substance Abuse Treatment Professional (QSATP) with training in prevention strategies and procedures.

(3) Outpatient services.**(a) Outpatient services may include:**

1. Individual therapy;
2. Group therapy;
3. Family therapy. This service is counseling provided to an eligible individual and one (1) or more significant others with the primary purpose of which is the treatment of the individual's condition;
4. Psychiatric evaluation provided by a psychiatrist;
5. Psychological testing provided by a psychologist;
6. Medication management provided by a physician or an advanced registered nurse practitioner; and
7. Collateral care. Involves counseling or consultation services provided directly or indirectly to the recipient through the involvement of a person or person's in a position of custodial control or supervision of the individual in the counseling process. Services are to meet the treatment needs of the eligible individual and shall be a part of the individual's treatment plan. Presence of the recipient in the counseling session is not necessarily required. However, when the recipient is present, reimbursement for the collateral counseling and individual or group counseling for the same session is not allowed.

(b) Service limitations

1. Group therapy.
 - a. There shall be no more than twelve (12) persons in a group therapy session, and
 - b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.
2. Collateral care shall be limited to individuals under age twenty-one (21) and no more than four and one-half (4.5) hours of service shall be reimbursed during a one (1) month period
3. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period

20.b. Rehabilitative Services for Pregnant Women (continued)**(4) Day Rehabilitation Services.**

- (a) Shall be an array of substance abuse treatment services in a structured program format that is scheduled to take place multiple hours a day, several times a week and may include individual and group therapy, information on substance abuse and its effects on health, fetal development and interpersonal relationships
- (b) May be covered when provided to an individual in a non-residential setting or as a component of a residential program.
- (c) Service limitations:
 1. Reimbursement for a day rehabilitation service provided in a non-residential setting shall be limited to no more than 7 hours per day not to exceed twenty (20) hours per week.
 2. Reimbursement for a day rehabilitation service provided in a residential setting shall be limited to no more than 8 hours per day not to exceed forty-five (45) hours per week.
 3. Payment shall not be made for care or services for any individual who is a patient in an institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.
 4. Room and board costs shall not be covered under this benefit.

(5) Outpatient and Day Rehabilitation services shall be provided by a qualified substance abuse treatment professional (QSATP) that meets one of the following requirements:

- (a) A certified alcohol and drug counselor; or
- (b) An individual who holds a license or certification in medicine, psychology, social work, nursing, marriage and family therapy, professional counselor, or art therapy with 24 hours of additional training in substance abuse or dependency related problems and information specific to working with the target population; or
- (c) A bachelor's or greater degree with additional training of 45 hours with 12 hours in substance abuse or dependence related problems, 12 hours specific to the target population, 12 hours in prevention strategies and procedures, and the remaining 9 hours may be in one or more of the identified training topics.

(6) Community support services.

- (a) A community support service shall be provided if the service is identified as a need in the individual's treatment plan.
- (b) A community support service shall be a face-to-face or telephone contact between an individual and a qualified community support provider.
- (c) A community support service shall include:
 1. Assisting an individual in remaining engaged with substance abuse treatment or community self-help groups.
 2. Assisting an individual in resolving a crisis in an individual's natural environment; and

20.b. Rehabilitative Services for Pregnant Woman (continued)

3. Coaching an individual in her natural environment to:
 - a. Access services arranged by a case manager; and
 - b. Apply substance abuse treatment gains, parent training and independent living skills to an individual's personal living situation.

- (d) A community support provider shall coordinate the provision of community support services with an individual's primary provider of case management services.

- (e) Community support staff qualifications.
 1. A high school diploma or general equivalent diploma.
 2. Two years of supervised experience in substance abuse treatment setting and knowledge of substance abuse related self-help groups.
 3. Twenty hours of training on the dynamics and treatment of substance abuse, recovery issues unique to pregnant women and women with dependant children and HIV positive individuals, strategies to defuse resistance, professional boundary issues that address enabling behaviors and protecting a staff member, who may be a recovering substance abuser, from losing their own sobriety.

- (7) Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility.
 - (a) Reimbursement for services shall be based on the following units of service:
 1. Universal prevention service shall be a one-quarter (1/4) hour unit;
 2. Selective prevention service shall be a one-quarter (1/4) hour unit;
 3. Indicated prevention service shall be a one-quarter (1/4) hour unit;
 4. Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:
 - a. Individual therapy;
 - b. Group therapy;
 - c. Family therapy;
 - d. Psychiatric evaluation;
 - e. Psychological testing;
 - f. Medication management; and
 - g. Collateral care.
 5. An assessment service shall be a one-quarter (1/4) hour outpatient unit;
 6. Day rehabilitation services shall be a one (1) hour unit;
 7. Case management services shall be a one-quarter (1/4) hour unit; and
 8. Community support shall be a one-quarter (1/4) hour unit.

 - (b) Qualifications of Providers
 1. Services are covered only when provided by any mental health center, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations.
 2. The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
 3. A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.

State Kentucky

§ Hospice Limitation

The following hospice limitation is applicable: A Medicaid eligible individual who wishes to elect coverage under Medicaid for hospice care and who is eligible for hospice care under Medicare, must elect coverage under both programs for coverage to exist under Medicaid.

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TX # 86-7

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24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.

A Transportation

1. Definitions

- a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.
- h. Medical service area is made up of the recipient's county of residence or a contiguous county.

2. Ambulance Services.

- a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.
- b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service, exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.
- c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medical necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.
- d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.
- e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.
- f. Only the least expensive available transportation suitable for the recipient's needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

- a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.
- b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.
- c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.
- d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.
- e. The Department will cover the following specially authorized transportation services:
 - (1) Transportation for a recipient;
 - (2) Lodging for a recipient, and a parent or attendant, if necessary;
 - (3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;
 - (4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and
 - (5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

²¹
23.d. Nursing Facility Services for Patients Under 21 Years of Age

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures x-ray, oxygen and oxygen supplies, and ventilator use.

²¹
~~27~~.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided: With limitations

Not provided.

20. Extended services to pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Provided: Additional coverage ⁺⁺

- b. Services for any other medical conditions that may complicate pregnancy.

Provided: Additional coverage ⁺⁺

Not provided.

- c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(10)(A)(ii)(IX) of the Act.

Provided: Additional coverage ⁺⁺

Not provided.

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 99-08 Approval Date JUL 31 2001 Effective Date 10-20-99
Supersedes
TN No. 92-1
HCFA ID: 79862

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Provided: No limitations With limitations*

Not provided.

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).

Provided: No limitations With limitations*

Not provided

23. Certified pediatric or family nurse practitioners' services.

Provided: No limitations With limitations*

Not provided.

See item 6d for limitations.

* Description provided on attachment.

TN No. 01-21
Supersedes
TN No. 92-01

Approval Date DEC 17 2001 Effective Date 11/1/01

State/Territory Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law,
specified by the Secretary.

a. Transportation.

Provided: No limitations With limitations*

Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

Provided: No limitations With limitations*

Not provided.

c. Reserved

d. Nursing facilities for patients under 21 years of age.

Provided: No limitations With limitations*

Not provided.

e. Emergency hospital services.

Provided: No limitations With limitations*

Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of
treatment and provided by a qualified person under supervision of a registered nurse.

Provided: No limitations With limitations*

Not provided.

* Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

No limitations

With limitations

Transportation is limited to individuals requesting transportation who lack access to free transportation that meets their medical needs. Transportation is only authorized for a Medicaid-covered service that has been determined medically necessary.

a 2. Brokered Transportation

Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

(1) statewideness (indicate areas of State that are covered)

(10)(B) comparability (indicate participating beneficiary groups)

(23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the regional broker and the provider assigned by the broker for the recipient's trip.

(2) Transportation services provided will include:

wheelchair van

taxi

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- stretcher car
- bus passes
- tickets
- secured transportation
- such other transportation as the Secretary determines appropriate (please describe): **Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.**

Private auto providers enroll via the same enrollment and credentialing process as other Medicaid providers and submit additional enrollment documents specific to the transportation program including vehicle registration, vehicle insurance coverage and a valid driver's license. This category of provider is defined in Kentucky Revised Statute 281.873.

Private auto providers are reimbursed the Kentucky State Employee mileage rate in effect for the given time period.

(3) The State assures that transportation services will be provided under a contract with a broker who:

- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
- (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
- (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
- (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- Low-income families with children (section 1931)
- Low-income pregnant women
- Low-income infants
- Low-income children 1 through 5
- Low-income children 6 – 19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- Qualified pregnant women
- Qualified children
- IV-E Federal foster care and adoption assistance children
- TMA recipients (due to employment)
- TMA recipients (due to child support)
- SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

- Optional low-income pregnant women
- Optional low-income infants
- Optional targeted low-income children
- Individuals under 21 who are under State adoption assistance agreements
- Individuals under age 21 who were in foster care on their 18th birthday
- Individuals who meet income and resource requirements of AFDC or SSI
- Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
- Individuals terminally ill if in a medical institution and will receive hospice care
- Individuals aged or disabled with income not above 100% FPL
- Individuals receiving only an optional State supplement in a 209(b) State
- Individuals working disabled who buy into Medicaid (BBA working disabled group)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

(6) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers)

Under a brokerage system, Kentucky is divided into fifteen (15) Non-Emergency Medical Transportation Regions which were established based upon regional medical utilization and referral patterns. The broker contract for each region is bid separately; however, a broker may be a successful bidder for more than one region. Each region has a single per member per month (PMPM) capitation rate which is paid to the regional broker for all transportation eligible recipients in that region. A single payment for each broker is made each month on a prospective basis. In the event one broker gains the contract in multiple regions, a blended PMPM rate is paid for all regions served by that broker.

The PMPM rate for each region is established based on historical utilization and cost patterns for the region. The PMPM rate for each region may be updated annually effective July 1st of each year if encounter data trends indicate that a region has experienced an increase in transportation utilization and/or cost which was outside of the control of the broker. PMPM rates may also be adjusted on an as needed basis if programmatic changes (i.e. State Plan or waiver changes) would result in a change in transportation utilization or if transportation cost factors (i.e. gas prices) result in a change in the projected cost of transportation.

If for any reason, a broker's contract is terminated before a replacement broker can be procured, non-emergency transportation reimbursement will revert to the methods applicable to non-emergency transportation described in Attachment 4.19-B, Section VII of the State Plan.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

provided

not provided

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

X Provided No limitations With Limitations* Not Provided

*Description provided on attachment.

TN No. 03-06

Supersedes

TN No. none

Approval Date 01-01-03

Effective Date 01-01-03

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY**

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury, and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90)-day period for the same injury or condition.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 05-010
Supersedes
TN No.: NEW

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Effective Date: 01/01/06

STATE PLAN UNDER TITLE SIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	<p data-bbox="630 667 1450 850">1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit Part D.</p> <p data-bbox="630 884 1284 919">The following excluded drugs are covered:</p> <ul style="list-style-type: none"><li data-bbox="630 957 1472 1035"><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)<li data-bbox="630 1073 1227 1150"><input type="checkbox"/> (b) agents when used to promote fertility (see specific drug categories below)<li data-bbox="630 1188 1354 1266"><input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)<li data-bbox="630 1304 1430 1381"><input type="checkbox"/> (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)<li data-bbox="630 1419 1398 1514"><input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)<li data-bbox="630 1551 1214 1627"><input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)

TN No.: 05-010
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TN No.: NEW

Approval Date: 11/25/05

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	<p data-bbox="618 632 1472 814"><input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</p> <p data-bbox="618 852 1472 888"><input checked="" type="checkbox"/> (h) barbiturates</p> <p data-bbox="618 926 1472 961"><input checked="" type="checkbox"/> (i) benzodiazepines</p> <p data-bbox="711 999 1393 1073">(The Medicaid agency lists specific category of drugs below)</p> <p data-bbox="711 1110 1463 1289"><u>Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.</u></p>

 No excluded drugs are covered.

TN No.: 05-010
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TN No.: NRW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than state-wide:

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(continued on next page)

TN # 88-23
Supersedes
TN # 87-15

Approval Date APR 28 1989 Effective Date 10-1-88

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate.

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
 - (a) assessment
 - (b) care/services plan development
 - (c) linking/coordination of services
 - (d) reassessment/followup
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(Continued on next Page)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.
 2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.
7. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
8. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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HCFA ID: 1040P/0016P

Targeted Case Management Services for Severely Emotionally Disturbed Children

A. Target Groups: By involving the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Age 0-21 and meet the state's conditions and circumstances to be defined as a "severely emotionally disturbed child."

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than state-wide:

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 (a) (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

-
- (1) A written, comprehensive assessment of the child's needs;
 - (2) Arranging for the delivery of the needed services as identified in the assessment;
 - (3) Assisting the child and his family in accessing needed services;
 - (4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs;
 - (5) Performing advocacy activities on behalf of the child and his family;
 - (6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
 - (7) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress); and
 - (8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Provider participation shall be limited to the Kentucky Department for Social Services and the fourteen Regional Mental Health Mental Retardation Centers, licensed in accordance with state regulations.

Qualifications of Case Manager and Supervision Requirement

- (1) Case Manager Qualifications. Each case manager shall be required to meet the following minimum requirements:
 - (a) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the behavioral sciences from an accredited institution; and
 - (b) Have one (1) year of experience working directly with children or performing case management services (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and
 - (c) Have received training within six (6) months designed and provided by each participating provider directed toward the provision of case management services to the targeted population; and

(d) Have supervision for a minimum of one (1) year by a mental health professional; i.e., psychiatrist, psychologist, master's level social worker (MSW), psychiatric nurse or professional equivalent (a minimum of a bachelor's degree in a human services field, with two (2) years of experience in mental health related children's services). The supervisor shall also complete the required case management or training course.

(2) Case Manager Supervision Requirement. For at least one (1) year, each case manager shall have supervision performed at least once a month for each case plan.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 19C2(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.

(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

- A. **Target Groups:** By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and
 2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.
- B. **Areas of State in which services will be provided:**
- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the act is invoked to provide services less than statewide):
- C. **Comparability of Services**
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. **Definition of Services:** Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

-
- (1) A written assessment of the child or adult's needs;
 - (2) Arranging for the delivery of the needed services as identified in the assessment;
 - (3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult.
 - (4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;
 - (5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs.
 - (6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc following provision of service to the child or the adult on behalf of the child or adult.
 - (7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and
 - (8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

- (1) Demonstrated capacity to provide all core elements of case management including
 - (a) assessment;
 - (b) care/services plan development;
 - (c) linking/coordination of services; and
 - (d) reassessment/follow-up
- (2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations

-
- (3) Demonstrated experience with one of the target populations.
 - (4) An administrative capacity to insure quality of services in accordance with state and federal requirements.
 - (5) Have a financial management system that provides documentation of services and costs
 - (6) Capacity to document and maintain individual case records in accordance with state and federal requirements.
 - (7) Demonstrated ability to assure a referral process consistent with Section 1902(a)(23) of the Act, freedom of choice of provider.
 - (8) Demonstrated capacity to meet the case management service needs of the target population.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

- (1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
 - (2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 Participating in the Kentucky Early Intervention Program

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

- 1 Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

- (1) Assessment of child's medical, social and functional status and identification of service needs;
- (2) Initial service coordination from notice of referral through initial IFSP development;
- (3) Assuring that all procedural safeguards are met during intake and IFSP development;
- (4) Arranging for and coordinating the development of the child's IFSP;
- (5) Arranging for the delivery of the needed services as identified in the IFSP;
- (6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
- (7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
- (8) Performing activities to enable an eligible individual to gain access to needed services;
- (9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

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- (11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
 - (12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915 (g)(1) of the Social Security Act, qualified providers shall be the Title V agencies and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:
 - a) assessment;
 - b) care/ services plan development;
 - c) linking/ coordination of services; and
 - d) reassessment/ follow-up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population
3. Demonstrated experience with targeted population;
4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and
5. A financial management system that provides documentation of services and costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

- A. Have a Bachelor's degree; and
- (1) 2 years experience in service coordination for children with disabilities up to age 18; or
 - (2) 2 years experience in service provision to children under six years of age; or
- B. Meet one of the following professional criteria:
- 1. Audiologist - Licensed or Certified,
 - 2. Family Therapist - M.A. and Certified,
 - 3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
 - 4. Developmental Associate,
 - 5. Registered Nurse,
 - 6. Advanced Registered Nurse Practitioner,
 - 7. Dietitian - Licensed,
 - 8. Occupational Therapist - Licensed,
 - 9. Occupational Therapist Assistant - B.S. and Licensed,
 - 10. Orientation and Mobility Specialist - Certified,
 - 11. Physical Therapist - Licensed,
 - 12. Psychologist - Licensed or Certified,
 - 13. Speech Language Pathologist - Licensed or Certified,
 - 14. Speech Language Assistance - Licensed,
 - 15. Social worker - Licensed,
 - 16. Physician, Licensed,
 - 17. Nutritionist, Licensed

- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

- A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Pregnant women who have not reached their twentieth birthday and will be first time teen parents;
 2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program which shall be called Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed, inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
 3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
 4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.

B. Areas of State in which services will be provided:

 Entire State Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than state wide:

C. Comparability of Services:

 Services are provided in accordance with 1902(a)(10)(B) of the Act. Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).

D. Definition of Services

Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirement of Section 1902(a)(23) of the Act, the providers will monitor client treatment to

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assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment
 - a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;
 - b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:
 - 1) parent's childhood experience;
 - 2) lifestyle behaviors and mental health status;
 - 3) parenting experience;
 - 4) stressors, coping skills and support system for the new family;
 - 5) anger management skills;
 - 6) expectations of infant's developmental milestones and behaviors;
 - 7) perception of new infant, and bonding and attachment issues;
 - 8) plans for discipline; and
 - 9) family environment and support system.
 - c) Develops a written report of the findings and a service plan for the family.
 - d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

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2. Home Visitation

- a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker or early childhood development specialist may perform a home visit;
- b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;
- b) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;
- c) Perform activities to enable the child and family to gain access to needed services;
- d) Prepare and maintain case records documenting contacts, services needed, reports, progress;
- e) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and
- f) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

- 1. Providers must be certified as a Medicaid provider meeting the following criteria:
 - a) Demonstrated capacity to contract statewide for the case management services for the targeted population;
 - b) Demonstrated capacity to ensure all components of case management including:
 - 1) screening,
 - 2) assessment,
 - 3) treatment plan development,
 - 4) home visiting,
 - 5) linking/coordination of services, and
 - 6) follow-up and evaluation;
 - c) Demonstrated experience in coordinating and linking such community resources as required by the target population;
 - d) Demonstrated experience with the target population;

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- e) Administrative capacity to insure quality of services in accordance with state and federal requirements;
 - f) Demonstrated capacity to provide certified training and technical assistance to case managers;
 - g) Financial management system that provides documentation of services and costs;
 - h) Capacity to document and maintain individual case records in accordance with state and federal requirements;
 - i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and
 - j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

- a) Registered Nurse – Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.
- b) Social Worker – Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.
- c) Early Childhood Development Specialist – have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.
- d) Family Support Worker (FSW) – Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, HIV/AIDS training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

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- F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- i. Eligible recipients will have free choice of the providers of case management services.
 - 2. Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Targeted Case Management services for pregnant women including postpartum women for sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

A. By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

(1) Women diagnosed as a pregnant woman or postpartum woman up to the end of the month of sixty days following the date of delivery who has applied for or is receiving substance abuse services through Medicaid.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services. Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

(1) Substance abuse case management services:

(a) Case management shall be:

1. A face-to-face or telephone contact between or on behalf of an individual and a qualified substance abuse professional, and
2. For the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.

(b) Case management services shall include

1. The development of a service plan that identifies an individual's case management needs and projected outcomes; and
2. Activities that support the implementation of an individual's service plan.

(c) Case management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in an individual's treatment plan.

- (d) Service limitations. The following activities shall not be reimbursed by Medicaid:
1. An outreach or case-finding activity to secure a potential individual for services;
 2. Administrative activities associated with Medicaid eligibility determinations; and
 3. The actual provision of a service other than a case management service.

A. Qualifications of Providers:

- (1) Services are covered when provided by any mental health center, and their subcontractors, and any other qualified providers, licensed in accordance with applicable state laws and regulations.
- (2) Demonstrated capacity to provide all core elements of case management including : Assessment skills, care/services plan development, linking/coordination of services, reassessment/follow-up, training specific to the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements and a financial system that provides documentation of services and costs.
- (3) The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
- (4) A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.
- (5) Qualifications for case management services:
 - (a) An alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors;
 - (b) An individual who has a bachelors degree or greater in any field, from an accredited college or university who meets the training, documentation and supervision requirements;
 - (c) A Kentucky licensed physician.
 - (d) A psychiatrist who is licensed in Kentucky.
 - (e) A psychologist licensed or certified by the Kentucky Board of Examiners of Psychology;
 - (f) A psychological associate certified by the Kentucky Board of Examiners of Psychology;

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- (g) A social worker licensed or certified in Kentucky.
 - (h) A Kentucky licensed registered nurse with the following combination's education and work experience:
 - 1. A registered nurse with a masters degree in psychiatric nursing from an accredited college or university.
 - 2. A bachelor of science degree in nursing from an accredited college or university and one year of clinical work experience in the substance abuse or mental health field.
 - 3. A diploma graduate in nursing and two years of clinical work experience in the substance or mental health field; or
 - 4. An associate degree in nursing from an accredited college or university and three years of clinical work experience in the substance abuse or mental health field.
 - (i) A Kentucky licensed advanced registered nurse practitioner.
 - (j) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists.
 - (k) A Kentucky-certified professional counselor; or
 - (l) A Kentucky-certified professional art therapist.
- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

