Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH

Steven Stack, MD
SECRETARY

275 East Main Street, HS1GW-A
Frankfort, Kentucky 40621
Phone: (502) 564-3970
Fax: (502) 564-9377

December 3, 2025

FILED WITH LRC
TIME: 1:40pm
DEC 03 2025
Emily B Caudill
REGULATIONS COMPILER

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
083, Capitol Annex
702 Capitol Ave.
Frankfort, KY 40601

Re: 902 KAR 100:130. Dental.

Dear Co-Chairs,

After consideration of the issues raised by 902 KAR 100:130, the Department for Public Health proposes the attached suggested substitute to this administrative regulation.

If you have any questions regarding this matter, please contact Julie Brooks, Department for Public Health, at (502) 229-3377.

Sincerely,

Krista Quarles

Krista Quarles
Policy Analyst
Office of Legislative and Regulatory Affairs

Final, 11-17-2025

SUGGESTED SUBSTITUTE

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Public Health Protection and Safety

902 KAR 100:130. Dental.

RELATES TO: KRS 211.842-211.852, 211.990(4), 21 C.F.R. ***Part 1020[~~1020.30~~]***
STATUTORY AUTHORITY: KRS 194A.050, 211.090, 211.844
CERTIFICATION STATEMENT:
NECESSITY, FUNCTION, AND CONFORMITY: ***[~~The Cabinet for Health and Family Services~~]***[~~Human Resources~~]***[~~ is authorized by ~~]***KRS 211.844 ***requires the Cabinet for Health and Family Services*** to provide by administrative regulation for the registration and licensing of the possession or use of any sources of ionizing or electronic product radiation and the handling and disposal of radioactive waste. [~~The purpose of ~~]This administrative regulation establishes the[~~is to provide special~~] requirements for the possession, use, and operation of intraoral[~~intra-oral~~] dental radiographic x-ray systems.

Section 1. Applicability. This administrative regulation shall apply to dental intraoral[~~intra-oral~~] radiographic x-ray systems and to persons, equipment, and materials used in connection with the possession, use, or operation of these systems.

Section 2. Source to Skin Distance. Each radiographic x-ray system designed for use with an intraoral[~~intra-oral~~] image receptor shall be provided with a means to limit the source to skin distance to not less than[~~:~~]
[~~(1)~~] eighteen (18) centimeters[~~ if operable above fifty (50) kilovolts peak; or~~]
[~~(2)~~] [~~Ten (10) centimeters if not operable above fifty (50) kilovolts peak~~].

Section 3. Field Limitation. Each radiographic x-ray system designed for use with an intraoral[~~intra-oral~~] image receptor shall be equipped[~~provided~~] with a means to limit the x-ray beam.
(1) If the minimum source to skin distance [~~(SSD) ~~]is eighteen (18) centimeters or more, the x-ray field[~~, at the minimum SSD,~~] shall be containable in a circle having a diameter of no more than seven (7) centimeters.[~~; or~~]
(2) Circular beams are permitted, but the cabinet recommends the use of rectangular collimation.
(3) The useful beam shall be limited to the area of clinical interest[~~If the minimum SSD is less than eighteen (18) centimeters, the x-ray field, at the minimum SSD, shall be containable in a circle having a diameter of no more than six (6) centimeters~~].

Section 4. Operator and Public Protection.
(1) Except for hand-held x-ray systems with integral shields, each installation shall be provided with a protective barrier for the operator or shall be***[~~ so~~]*** arranged ***so*** that the operator can conveniently stand[~~, in the judgment of the cabinet,~~] at least six (6) feet[~~one and eight tenths (1.8) meters~~] from the patient, the tube housing assembly, and outside the path of the useful x-ray beam while making an exposure.
(2) If six (6) feet cannot be maintained, a barrier shall be provided, with the ability to view the patient, while making the exposure.
(3) The operator shall monitor and secure the area prior to making an exposure near public areas.
(4) In dental facilities using a large, multi-patient open-bay design, a patient in proximity to another patient being radiographed shall be treated as a member of the public.
(5) All public areas shall comply with the applicable requirements of 902 KAR 100:019[~~if the exposure to the operator is within the limits provided by 902 KAR 100:020, Section 20~~].

Section 5. Operating Procedures. In performing intraoral[~~intra-oral~~] dental radiography, the ***[~~following~~]*** rules ***as established in this section*** shall apply***.[~~:~~]***

(1) Patient and image receptor film holding devices shall be used if technique permits.[~~;~~]

(2) Except for units designed to be hand-held, the tube housing and position indicating device shall not be hand-held during an exposure.

(3) ***An[~~No~~]*** individual shall ***not*** be used routinely to hold the image receptor or patient during a radiation exposure.

(4) ***(a)*** The registrant shall restrict the presence of individuals in the area ***where[~~of~~]*** the patient ***is*** being radiographed.

(b) Parents or guardians may accompany a child or person with special needs.

(c) Those persons ***present in the area where the patient is being radiographed*** shall be***:***

1. Positioned so that no part of their body is exposed to the primary beam***;*** and

2.[~~be~~] Protected from secondary radiation by protective lead shielding to not less than 0.25 millimeter lead equivalent material.

(5) A sufficient number of protective apparel (e.g., aprons, gloves, thyroid collars) and auxiliary shields shall be available to provide the necessary radiation protection for all patients and personnel who are involved with x-ray operations.

(a) All protective apparel and auxiliary shields shall be evaluated annually for integrity and clearly labeled with their lead equivalence.

(b) Shielding shall be provided for patients ***if[~~when~~]*** it will not interfere with the examination.

(c) In accordance with guidance from a qualified expert, registrants implementing dose reduction technologies (e.g., position-indicating device ***twenty (***20***) – thirty (***30***) centimeters[~~cm~~]***, rectangular collimation, fast digital image receptors) and procedures, may develop and submit to the cabinet for approval their own policies and procedures regarding human patient protection, exposure of pregnant patients, patient shielding, and patient education.

(6) The registrant shall annually review their radiation protection program in accordance with 902 KAR 100:019, Section 2.

(7) The registrant shall maintain and make available safe operating procedures to include written safety procedures and techniques required for the safe use of the x-ray system.

(8) Image receptors of speeds slower than ***the American National Standards Institute (***ANSI***)*** speed group E/F or D speed shall not be used for intraoral radiography.

(9) Dental fluoroscopy without image intensification shall not be used.

(10) Technique factors and selection criteria shall be appropriate to the age and size of the patient.

(11) The registrant shall maintain a quality control program that complies with 902 KAR Chapter 100[~~Neither the tube housing assembly nor the position indicating device shall be hand-held during an exposure;~~]

[~~(3)~~] [~~The x-ray system shall be arranged and operated in a manner that the useful beam at the patient's skin does not exceed the dimensions specified in Section 3 of this administrative regulation.~~]

[~~(4)~~] [~~Each patient undergoing dental radiography shall be draped with a protective apron of not less than 0.25 mm lead equivalent to cover the gonadal area;~~]

[~~(5)~~] [~~Film of a USASI (USA) speed group rating of "D" or faster shall be used;~~]

[~~(6)~~] [~~All dental radiographic x-ray systems registered after March 2, 1977, shall be provided with electronic timers; and~~]

[~~(7)~~] [~~If patients are immobilized during an x-ray exposure mechanical restraints shall be used if technique permits~~].

Section 6. Beam Quality. The half-value layer of the useful beam shall:

(1) Not be less than the value specified in 21 C.F.R. 1020.30(m), Table 1; and

(2) Meet requirements specified in 21 C.F.R. ***1020.30[~~1012.30~~]***(m)(1).

Section 7. Leakage Radiation. The leakage radiation from the diagnostic source assembly shall be measured in accordance with 21 C.F.R. 1020.30(k).

Section 8. ***Kilovolt Peak (***kVp***)*** Accuracy. The kVp accuracy shall be within plus or minus ten (10) percent of its indicated value.

Section 9. Coefficient of Variation. The coefficient of variation for timing, radiation exposure, and reproducibility shall not exceed 0.05 in four (4) consecutive exposures.

Section 10. Maintaining Compliance. Diagnostic x-ray systems and their associated components used on humans and certified pursuant to the Federal X-Ray Equipment Performance Standards for Ionizing Radiation Emitting Products, 21 C.F.R. Part 1020, shall be maintained in compliance with applicable requirements of that standard.

Section 11. Additional Requirements. ***[~~In addition to the requirements of this administrative regulation, ~~]***Dental intraoral x-ray systems shall:

(1) Provide a visual and audible indication ***that*** x-rays are being produced***;[.]***

(2) Utilize a "dead-man" exposure switch***;[.]***

(3) Provide a means to terminate the exposure at a preset:

(a) Time interval;

(b) Product of current and time;

(c) Number of pulses; or

(d) Radiation exposure to the image receptor***;[.]***

(4) Display their technique factors prior to exposure:

(a) If automatic exposure controls are used, the technique factors, which are set prior, shall be indicated; or

(b) May be met by permanent display of markings on x-ray systems using fixed technique factors***;[.]***

(5) Have tube housing assembly supports so that the tube housing assembly remains stable during the exposure unless tube housing movement is a designed function of the x-ray system***; and[.]***

(6) Not be operated at less than ***fifty (***50***)*** kVp.

Section 12. Hand-held Devices. In addition to the standards in 902 KAR Chapter 100, the following ***standards established within this section apply[~~applies~~]*** specifically to intraoral hand-held devices.

(1) Any dental intraoral hand-held x-ray system used shall be cleared by the Federal Food and Drug Administration prior to use.

(2) The hand-held x-ray system shall be equipped with a backscatter shield of not less than ***(0.25)[~~.25~~]*** millimeter lead equivalent.

(3) The registrant shall maintain documentation that each operator has completed training as specified by the manufacturer ***and[.]*** to ensure the operator is competent in the safe use of the x-ray system.

(4) The training required by subsection (3) of this section shall, at a minimum, contain:

(a) ***The*** basics of x-ray production and scatter***;[.]***

(b) ***The As Low as Reasonably Achievable (***ALARA***)*** principle and basic protective measures to include time, distance, and shielding; and

(c) ***Instruction on the*** proper positioning of the patient and operator, location and orientation of the handheld device, and operator's hand positioning on the device.

(5) ***If[~~When~~]*** the hand-held x-ray system is not in use***, then*** it shall be secured and stored so that it is not accessible to members of the public.

(6) The registrant shall provide personal dosimeters for all new hand-held x-ray system operators to determine if further monitoring is required pursuant to 902 KAR 100:***019,[~~19~~]*** Section ***3***.[~~Filtration. In addition to the requirements of 902 KAR 100:115, Section 6, all intra-oral dental radiographic systems manufactured on and after December 1, 1980, shall have a minimum half-value layer not less than one and five- tenths (1.5) millimeters aluminum equivalent filtration permanently installed in the useful beam.~~]

[~~Section 7.~~] [~~Linearity. On dental intra-oral radiographic systems certified under the federal performance standard, if the equipment allows a choice of x-ray tube current settings and is operated on a power supply as specified by the manufacturer in accordance with the requirements of applicable federal~~

~~standards, for any fixed x-ray tube potential within the range of forty (40) to 100 percent of the maximum rating, the average ratios of exposure to the indicated milliampere-seconds product obtained at any two (2) consecutive tube current settings shall not differ by more than one-tenth (0.1) times their sum.~~]

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6W-A
Frankfort, Kentucky 40621
@chfsky | CHFS.KY.GOV

Steven Stack, MD
SECRETARY

Lisa D. Lee
COMMISSIONER

December 3, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

FILED WITH LRC
TIME: 1:40 pm
DEC 03 2025
Emily B Caudill
REGULATIONS COMPILER

907 KAR 1:065. Payments for price-based nursing facility services.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 1:065, the Department for Medicaid Services proposes the attached suggested substitute to 907 KAR 1:065.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Office of Legislative and Regulatory Affairs
Cabinet for Health and Family Services

Final, 12-3-2025

SUGGESTED SUBSTITUTE

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy

907 KAR 1:065. Payments for price-based nursing facility services.

RELATES TO: KRS 142.361, 142.363, 216.380, 42 C.F.R. Parts 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 482.58, 483.10, 483.20, 42 U.S.C. 1395tt, 1396, 1396a, 1396b, 1396c, 1396d, 1396g, 1396l, 1396n, 1396o, 1396p, 1396r, 1396r-2, 1396r-5
STATUTORY AUTHORITY: KRS 142.361(5), 142.363(3), 194A.030(2), 194A.050(1), 205.520(3)
CERTIFICATION STATEMENT:
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid program for services provided by a price-based nursing facility.

Section 1. Definitions.
(1) "Ancillary service" means a direct service including:
(a) Ancillary services pursuant to 907 KAR 1:023; or
(b) If ordered by a physician:
1. Clinical laboratory procedures; or
2. X-rays or imaging services.
(2) "Appraisal" means an evaluation of a price-based nursing facility building, excluding equipment and land, conducted by the department in accordance with Section 4 of this administrative regulation for the purpose of calculating the depreciated replacement cost of a price-based nursing facility.
(3) "Appraisal base year" means a year in which the department conducts an appraisal of each price-based NF.
(4) "Auxiliary building" means a roofed and walled structure:
(a) Serviced by electricity, heating, and cooling;
(b) Independent of an NF;
(c) Used for administrative or business purposes related to an NF; and
(d) Constructed on the same tract of ground as an NF.
(5) "Capital rate component" means a calculated per diem amount for an NF based on:
(a) The NF's appraised depreciated replacement cost;
(b) A value for land;
(c) A value for equipment;
(d) A rate of return;
(e) A risk factor;
(f) The number of calendar days in the NF's cost report year;
(g) The number of licensed NF beds in the NF; and
(h) The NF's bed occupancy percentage.
(6) "Case-mix" means the time-weighted average price-based NF acuity for Medicaid-eligible and dual-eligible Medicare and Medicaid residents under a Medicare Part A reimbursed stay in a price-based nursing facility, and is based on Minimum Data Set (MDS) ***– Version*** 3.0 data classified through the Patient Driven Payment Model (PDPM) resident classification system or equivalent.

(7) "Core based statistical area" or "CBSA" means the designation of metropolitan and micropolitan population centers based on the national census, as published by the Federal Office of Management and Budget.
(8) "Department" means the Department for Medicaid Services or its designee.
(9) "Equipment" means a depreciable tangible asset, other than land or a building, which is used in the provision of care for a resident by an NF staff person.
(10) "Governmental entity" means a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).
(11) "Hospital-based NF" means an NF that:
(a) Is separately identifiable as a distinct part of the hospital; and
(b) If separated into multiple but distinct parts of a single hospital, is combined under one (1) provider number.
(12) "Land" means a surveyed tract or tracts of ground that share a common boundary:
(a) As recorded in a county government office;
(b) Upon which a building licensed as an NF is constructed; and
(c) Including site preparation and improvements.
(13) "Local unit of government" means a city, county, special purpose district, or other governmental unit in the state.
(14) "NF" or "nursing facility" means:
(a) A facility:
1. To which the state survey agency has granted an NF license;
2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and
3. To which the department has granted certification for Medicaid participation; or
(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R. 447.280, and 482.58.
(15) "NF building" means a roofed and walled structure serviced by electricity, heating, and cooling and that is also an NF.
(16) "Nursing facility with Medicaid waiver" or "NF-W" means an NF to which the state survey agency has granted a waiver of the nursing staff requirement.
(17) "Provider assessment" means the assessment imposed by KRS 142.361 and 142.363.
(18) "Routine services" means the services covered by the Medicaid program pursuant to 42 C.F.R. 483.10(f)(11)(i).
(19) "Site improvement" means a depreciable asset element, other than an NF building or auxiliary building, on NF land extending beyond an NF's foundation if used for NF-related purposes.
(20) "Standard price" means a facility-specific reimbursement that includes a case-mix adjusted component, noncase-mix adjusted component including an allowance to offset a provider assessment, noncapital-facility related component, and capital rate component.
(21) "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care.
(22) "Time-weighted" means a method of calculating case-mix by determining the number of days that a minimum data set (MDS) record is active over a calendar quarter rather than captured from a single day during the calendar quarter.

Section 2. NF Reimbursement Classifications and Criteria.
(1) An NF or a hospital-based NF shall be reimbursed as a price-based NF pursuant to this administrative regulation if:
(a) It provides NF services to an individual who:
1. Is a Medicaid recipient;
2. Meets the NF patient status criteria pursuant to 907 KAR 1:022; and
3. Occupies a Medicaid-certified bed; and
(b)
1. It has more than ten (10) NF beds and the greater of:
a. Ten (10) of its Medicaid-certified beds participate in the Medicare program; or

b. Twenty (20) percent of its Medicaid certified beds participate in the Medicare program; or

2. It has less than ten (10) NF beds and all of its NF beds participate in the Medicare program.

(2) An NF-W shall be reimbursed as a price-based NF pursuant to this administrative regulation if it meets the criteria established in subsection (1)(a) of this section.

(3) The following shall not be reimbursed as a price-based NF and shall be reimbursed pursuant to 907 KAR 1:025:

(a) An NF with a certified brain injury unit;

(b) An NF with a distinct part ventilator unit;

(c) An NF designated as an institution for mental disease;

(d) A dually-licensed pediatric facility; or

(e) An intermediate care facility for individuals with an intellectual disability.

Section 3. Reimbursement for Federally-Defined Swing Beds and for Skilled Nursing Facility Services in Critical Access Hospital Swing Beds.

(1) The reimbursement rate for a federally-defined swing bed shall be:

(a) The average rate per patient day paid to freestanding price-based NFs for routine services furnished during the preceding calendar year, excluding any payment made pursuant to Section ***15[14]*** of this administrative regulation; and

(b) Established effective January 1 of each year.

(2)

(a) The department shall reimburse a critical access hospital for skilled nursing facility services in a swing bed at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.

(b) The department shall pay an interim per diem rate as established by CMS for the Medicare program.

(c) The effective date of a rate shall be the same as used by the Medicare program.

(d) A critical access hospital's final reimbursement for skilled nursing facility services in a swing bed shall reflect any adjustment made by the Centers for Medicare and Medicaid Services.

(e) Total payments made to a critical access hospital for skilled nursing facility services provided in a swing bed under this section shall be subject to the payment limitation established in 42 C.F.R. 447.271.

(f) The provisions established in this subsection shall apply to a critical access hospital that complies with all requirements established in KRS 216.380.

Section 4. Price-based NF Appraisal.

(1) The department shall appraise a price-based NF to determine the facility specific capital component in 2009, and every fifth year, in order to calculate the NF's depreciated replacement cost.

(2) The department shall not appraise equipment or land. A provider shall be given the following values for land and equipment:

(a) Ten (10) percent of an NF's average licensed bed value for land; and

(b) $2,000 per licensed NF bed for equipment.

(3) The department shall utilize the following variables and fields of the nursing home or convalescent center CoreLogic Commercial Express Valuation System to appraise an NF identified in Section 2(1) of this administrative regulation:

(a) Provider number;

(b) Property owner - NF name;

(c) Address;

(d) Zip code;

(e) Section number - the lowest number shall be assigned to the oldest section and a basement, appraised as a separate section, immediately follows the section it is beneath;

(f) Occupancy code - nursing home or substructure;

(g) Average story height;

(h) Construction type;

(i) Number of stories;

(j) Gross floor area (which shall be the determination of the exterior dimensions of all interior areas including stairwells of each floor, specifically excluding outdoor patios, covered walkways, carports, and similar areas). In addition, interior square footage measurements shall be reported for:

1. A non-NF area;
2. A shared service area by type of service; and
3. A revenue-generating area;

(k) Gross perimeter (common walls between sections shall be excluded from both sections);
(l) Construction quality;
(m) Year built;
(n) Building effective age;
(o) Building condition;
(p) Depreciation percent;
(q) Exterior wall material;
(r) Roof covering material and roof pitch;
(s) Heating system;
(t) Cooling system;
(u) Floor finish;
(v) Ceiling finish;
(w) Partition wall structure and finish;
(x) Passenger and freight elevators - actual number;
(y) Fire protection system (sprinklers, manual fire alarms, and automatic fire detection) - percent of gross area served. If both the floor and attic areas are protected by a sprinkler system or automatic detection, the percent of gross area served shall be twice the floor area; and
(z) Miscellaneous additional features, which shall be limited to:

1. Canopies;
2. Entry foyers (sheltered entry ways):
   a. The glass and aluminum standard allowance shall be fifty (50) dollars per square foot;
   b. Bulkhead standard allowance shall be:
      (i) Eleven (11) dollars per square foot for a wood frame;
      (ii) Twelve (12) dollars per square foot for a steel frame; or
      (iii) Thirty-one (31) dollars per square foot for brick masonry;
3. Loading docks;
4. Code alerts, Wanderguards, or other special electronically-secured doorways, except for a door with a sound detector or sensing unit (the standard allowance shall be $1,420 for each fully-functioning door at the time of appraisal);
5. A door with a sound detector or sensing unit shall have a standard allowance of $865 per door;
6. Automatic sliding doors (the standard allowance shall be $25,450 per doorway);
7. An automatic door opener shall have a standard allowance of $9160 per door;
8. Detached garages or storage sheds (which shall have an attached reinforced concrete floor and a minimum of 200 square feet);
9. Modular buildings or trailers, if the structure has a minimum of 200 square feet, electrical service, and heating or cooling services (the standard allowance shall be eighty (80) dollars per square foot);
10. Walk-in coolers or freezers;
11. Laundry chutes (the standard allowance shall be $2,530 per floor serviced);
12. Dumb waiters (which shall have a minimum speed of fifty (50) feet per minute. The standard allowance shall be $20,500 for the initial two (2) stops for a manual door or $52,520 for the initial two (2) stops for an electric door and $5,050 per additional stop);
13. Skylights (the standard allowance shall be fifty-seven dollars per square foot);
14. Operable built-in oxygen delivery systems (valued at $425 per serviced bed);
15. Carpeted wainscoting (the standard allowance shall be eighty (80) dollars per licensed bed);
16. Balconies;
17. Ceiling fans for which the standard allowance shall be $375 for each ceiling fan without a light and $675 for each ceiling fan with a light;
18. Cupolas for which the standard allowance shall be $990 each;

19. Fireplaces;

20. Concrete-lined utility tunnels for which the standard allowance shall be thirty-two dollars per cubic foot; and

21. Mechanical penthouses.

(4) An item listed in subsection (3)(z) of this section shall be subject to the CoreLogic Commercial Express valuation system monetary limit unless a monetary limit is provided for that item in subsection (3)(z) of this section.

(5) The department shall use the corresponding CoreLogic Commercial Express valuation system default value for any variable listed in subsection (3) of this section if no other value is stated for that variable in subsection (3) of this section.

(6)

(a) Values from the most recent CoreLogic Commercial Express valuation system tables shall be used during an appraisal.

(b) An adjustment calculation shall be performed if the most recent CoreLogic Commercial Express valuation system tables do not correspond to an appraisal base year.

(7) In addition to an appraisal cited in subsection (1) of this section, the department shall appraise an NF identified in Section 2(1) of this administrative regulation if:

(a) The NF submits written proof of construction costs to the department; and

(b)

1. The NF undergoes renovations or additions costing a minimum of $150,000 and the NF has more than sixty (60) licensed beds; or

2. The NF undergoes renovations or additions costing a minimum of $75,000 and the NF has sixty (60) or fewer licensed beds.

(8) An auxiliary building shall be:

(a) Appraised if it rests on land, as defined in Section 1(12) of this administrative regulation; and

(b) Appraised separately from an NF building.

(9) To appraise an auxiliary building, the department shall utilize a CoreLogic Commercial Express valuation system model, if the model better fits the auxiliary building's use and type.

(10) If an NF building has beds licensed for non-NF purposes or a provider conducts business activities not related to the NF, the appraisal shall be adjusted between NF and non-NF activity. The appraiser shall determine if the adjustment shall be made by dividing the number of licensed NF beds by the total number of beds, or through the use of an adjustment factor determined in accordance with appraisal industry standards by the appraiser, regardless of the occupancy factor. For example, an adjustment factor may be used to apportion the appraisal by the percent of NF square footage relative to the square footage on non-NF-related business activities.

(11) Cost of an appraisal shall be the responsibility of the NF being appraised.

(12) A building held for investment, future expansion, or speculation shall not be considered for appraisal purposes.

(13) The department shall not consider the following location factors in rendering an appraisal:

(a) Climate;

(b) High-wind zone;

(c) Degree of slope;

(d) Position;

(e) Accessibility; or

(f) Soil condition.

Section 5. Standard Price Overview.

(1) Rates shall reflect the differential in wages, property values, and cost of doing business in rural and urban designated areas.

(2) On July 1 of each year, the department shall utilize the most recent Federal Office of Management and Budget's core based statistical area (CBSA) designations to classify an NF as being in an urban or rural area, with metropolitan areas always being classified as urban. The urban and rural designations shall be based on the location of the NF under the CBSA designation.

(3) The department shall utilize an analysis of fair-market pricing and historical cost for the following data:

(a) Staffing ratios;

(b) Wage rates;

(c) Cost of administration, food, professional support, consultation, and nonpersonnel operating expenses as a percentage of total cost;

(d) Fringe benefit levels;

(e) Capital rate component; and

(f) Noncapital facility-related component.

(4) The following components shall comprise the case-mix adjustable portion of an NF's standard price:

(a) The personnel cost of:

1. A director of nursing;
2. A registered nurse (RN);
3. A licensed practical nurse (LPN);
4. A nurse aide;
5. An activities staff person; and
6. A medical records staff person; and

(b) Nonpersonnel operating cost including:

1. Medical supplies; and
2. Activity supplies.

(5) The following components shall comprise the noncase-mix adjustable portion of an NF's standard price:

(a) Administration to include an allowance to offset a provider assessment;

(b) Nondirect care personnel;

(c) Food;

(d) Professional support; and

(e) Consultation.

(6) The following components shall comprise the facility and capital component of an NF's standard price:

(a) The noncapital facility-related component, which shall be a fixed, uniform amount for all price-based NFs; and

(b) The NF's capital rate component, which shall be facility specific.

(7) Excluding capital rate components, the following is an example of an urban and a rural price-based NF's standard price based on rebased wages at the 2024 level:

CBSA Designation	Case-Mix Adjustable Portion of Standard Price	Noncase-Mix Adjustable Portion of Standard Price Without Capital Rate Component	Total Standard Price Excluding Capital Rate Components
Urban	$160.33[~~160.14~~]	$133.70[~~101.81~~]	$294.03[~~261.95~~]
Rural	$136.05[~~135.87~~]	$121.58[~~89.68~~]	$257.63[~~225.55~~]

(8) A price-based NF's standard price may be:

(a) Adjusted for inflation every July 1 using the version of the CMS Nursing Home without Capital Market Basket that was effective on the July 1 that the inflation adjustment occurred; and

(b) Rebased:

1. Effective July 1, 2024; and
2. At least once every four (4) years thereafter.

(9) The department shall adjust an NF's standard price if:

(a) A governmental entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the inflation adjustment; or

(b) A new licensure requirement or new interpretation of an existing requirement by the state survey agency results in changes that affect all facilities within the class. The provider shall document that a cost increase occurred as a result of a licensure requirement or policy interpretation.

Section 6. Standard Price Calculation.

(1) Based on the classification of urban or rural, the department shall calculate an individual NF's standard price to be the sum of:

(a) The case-mix adjustable portion of the NF's standard price, adjusted by the NF's current case-mix index pursuant to Section 7 of this administrative regulation;

(b) The noncase-mix adjustable portion of the NF's standard price, which shall includean allowance to offset a provider assessment;

(c) The noncapital facility-related component; and

(d) Pursuant to subsection (2) of this section, the capital rate component.

(2) An NF's capital rate component shall be calculated as follows:

(a) The department shall add the total of:

1. The NF's average licensed bed value, which shall:

a. Be determined by dividing the NF's depreciated replacement cost, as determined from an appraisal conducted in accordance with Section 4 of this administrative regulation, adjusted every July 1 using the RS Means Construction Cost Indexes, and applying the total weighted average annual change of the Kentucky cities by the NF's total licensed NF beds; and

b. Not exceed $80,278[~~79,775~~] effective July 1, 2024[~~2023~~], which shall be adjusted every July 1 thereafter by the same factor applied to the NF's depreciated replacement cost;

2. A value for land, which shall be ten (10) percent of the NF's average licensed NF bed value, established in accordance with subparagraph 1. of this paragraph; and

3. A value for equipment, which shall be $2,000 per licensed NF bed;

(b) The department shall multiply the sum of paragraph (a) of this subsection by a rate of return factor, which shall:

1. Be equal to the sum of:

a. The yield on a twenty (20) year treasury bond as of the first business day on or after May 31 of the most recent year; and

b. A risk factor of two (2) percent; and

2. Not be less than nine (9) percent nor exceed twelve (12) percent;

(c) The department shall determine the NF's capital cost-per-bed day by:

1. Dividing the NF's total patient days by the NF's available bed days to determine the NF's occupancy percentage;

2. If the NF's occupancy percentage is less than ninety (90) percent, multiplying ninety (90) percent by 365 days; and

3. If the NF's occupancy percentage exceeds ninety (90) percent, multiplying the NF's occupancy percentage by 365 days; and

(d) The department shall divide the sum of paragraphs (a) and (b) of this subsection by the NF's capital cost-per-bed day established in paragraph (c) of this subsection to determine an NF's capital rate component.

(3) If a change of ownership occurs pursuant to 42 C.F.R. 447.253(d), the new owner shall:

(a) Receive the capital cost rate of the previous owner unless the NF is eligible for a reappraisal pursuant to Section 4(7) of this administrative regulation; and

(b) File an updated provider application with the Medicaid program pursuant to 907 KAR 1:672, Section 3(4).

(4) A new facility shall be:

(a) Classified as a new facility if the facility does not have a July 1, of the current state fiscal year, Medicaid rate;

(b) Determined to be urban or rural; and

(c) Reimbursed at its standard price, which shall:

1. Be based on a case-mix of 1.0;

2. Be adjusted prospectively based upon no less than one (1) complete calendar quarter of available MDS ***– Version*** 3.0 data following the facility's Medicaid certification;

3. Utilize $80,278[~~79,775~~] effective July 1, 2024[~~2023~~], as adjusted through the current state fiscal year as the facility's average licensed NF bed value until the facility is appraised in accordance with Section 4 of this administrative regulation; and

4. Be adjusted, if necessary, following the facility's appraisal if the appraisal determines the facility's average licensed NF bed value to be less than $80,278[~~79,775~~] effective July 1, 2024[~~2023~~], as adjusted through the current state fiscal year.

(5) The amounts calculated pursuant to subsection (4)(c)3. and 4. of this section shall be adjusted annually consistent with the adjustments made to the depreciated replacement cost, as described in subsection (2)(a)1.b. of this section for the capital component calculation.

Section 7. PDPM Adapted Minimum Data Set (MDS) ***– Version*** 3.0, and Validation.

(1) A price-based NF's Medicaid MDS data shall be utilized to determine its case-mix index each quarter.

(2) A price-based NF's case-mix index shall be applied to its case-mix adjustable portion of its standard price.

(3) To determine a price-based NF's case-mix index, the department shall:

(a) Calculate case-mix on a time-weighted basis using MDS data:

1. Extracted on the last date of each calendar quarter from the NF's MDS item sets:

a. Included in the PDPM Adapted Minimum Data Set (MDS) - Version 3.0, Resident Assessment and Care Screening; and

b. Transmitted by the NF to the Centers for Medicare and Medicaid Services; and

2. Which, if revised, shall be revised no later than the last date of the quarter following the date on which MDS data was extracted. For example, MDS data submitted after September 30, 2024[~~2023~~], for the purpose of revision to MDS data extracted June 30, 2024[~~2023~~], shall not be utilized;

(b) Classify the data cited in paragraph (a) of this subsection through the Patient Driven Payment Model (PDPM) resident classification system, nursing component; and

(c) Validate the data cited in paragraph (a) of this subsection as follows:

1. The department shall generate a stratified random sample of thirty (30) percent of the Medicaid residents in a price-based NF;

2. The department shall review one (1) MDS assessment from each resident in the sample referenced in subparagraph 1. of this paragraph; and

3. The department shall review medical records corresponding to the individuals included in the sample identified in subparagraphs 1. and 2. of this paragraph to determine if the medical records accurately support the MDS assessments submitted for the sample residents.

(4) If the department's review, in accordance with subsection (3)(c)3. of this section, of a price-based NF's MDS assessment data reveals that the NF fails to meet the MDS data minimum accuracy threshold, the department shall conduct another review of the same data utilizing an individual or individuals not involved in the initial validation process if the price-based NF requests a reconsideration within ten (10) business days of being notified of the findings of the review.

(5) Only MDS data extracted in accordance with subsection (3)(a)2. of this section shall be allowed during a review or reconsideration.

(6) If a reconsideration of a price-based NF's MDS assessment data, in accordance with subsection (4) of this section, confirms that the NF fails to meet the minimum accuracy threshold, the department shall:

(a) Conduct a conference with the NF to review preliminary findings of the reconsideration; and

(b) Send the final results of the reconsideration to the NF within ten (10) business days of the conference.

(7) In performing validation reviews on MDS data, the department shall:

(a) Notify the NF at the time of the MDS assessment review of any assessment that is not validated and allow the NF to provide supporting documentation that had been utilized to support the assessment;

(b) Consider all MDS supporting documentation provided by the NF prior to the exit conference; and

(c) Not consider MDS supporting documentation provided by the NF after the exit conference has occurred.

(8)

(a) Reconsideration of a price-based NF's MDS assessment data validation shall be provided if the NF:

1. Requests a reconsideration and clearly identifies each specific resident's review and MDS elements that are being disputed;

2. States the basis on which the department's decision on each issue is believed to be erroneous; and

3. Provides a summary supporting the NF's position.

(b) After a reconsideration of a price-based NF's MDS assessment data has been completed, the NF may appeal the department decision regarding the data in accordance with 907 KAR 1:671, Section 9.

(9)

(a) The department shall refer any suspected intentional alteration of clinical documentation or creation of documentation after an MDS assessment has been transmitted to the Office of Inspector General (OIG) for investigation of possible fraud.

(b) A fraud investigation may result in a felony or misdemeanor criminal conviction.

(10) An NF's rate shall be effective beginning on the first date of the second quarter following the MDS extraction date.

(11) An MDS validation review, if conducted, shall be initiated in the quarter[~~month~~] containing the corresponding rate effective date.

(12) A rate sanction shall be applied on the rate effective date following the validation review initiation date.

(13) MDS assessment accuracy thresholds and corresponding rate sanctions shall be established in accordance with this subsection.

(a) If a price-based NF's percentage of accurate MDS assessments is between sixty-five (65) and seventy-nine (79) percent, the price-based NF's rate shall be sanctioned by fifty (50) cents per patient day.

(b) If a price-based NF's percentage of accurate MDS assessments is between forty (40) and sixty-four (64) percent, the price-based NF's rate shall be sanctioned by sixty (60) cents per patient day.

(c) If a price-based NF's percentage of accurate MDS assessments is below forty (40) percent, the price-based NF's rate shall be sanctioned by seventy (70) cents per patient day.

[~~(d)~~] [~~Rate sanctions shall not be applied:~~]

[~~1.~~] [~~Until the rates effective July 1, 2025 are in effect; and~~]

[~~2.~~] [~~Except for those rates that are effective on and after July 1, 2025 as specified in subsection (14) of this section.~~]

(14) Beginning with rates effective July 1, 2025, upon conclusion of a departmental review of MDS data, in accordance with this section of this administrative regulation:

(a) The department shall recalculate the facility's case mix index based on the review's findings; and

(b) If a recalculated case mix index results in a change to the NF's established rate or rates, the rate or rates shall be recalculated and any payment adjustment shall be made.

(15) [~~For rates effective April 1, 2024, through June 30, 2024, the rate shall be equal to the rate effective January 1, 2024.~~]

[~~(16)~~] Beginning July[~~,~~] 1, 2024, the PDPM case-mix index shall be phased in.[~~using the following schedule:~~]

[~~(a)~~] [~~For rates effective July 1, 2024 through September 30, 2024, the case-mix index shall be comprised of twenty-five (25) percent of the PDPM CMI and seventy-five (75) percent of the RUG-III CMI that was in effect prior to the transition.~~]

[~~(b)~~] [~~For rates effective October 1, 2024 through December 31, 2024, the case-mix index shall be comprised of fifty (50) percent of the PDPM CMI and fifty (50) percent of the RUG-III CMI that was in effect prior to the transition.~~]

[~~(c)~~] [~~For rates effective January 1, 2025 through March 31, 2025, the case-mix index shall be comprised of seventy-five (75) percent of the PDPM CMI and twenty-five (25) percent of the RUG-III CMI that was in effect prior to the transition.~~]

(16)[~~(d)~~] Beginning April 1, 2025, the case-mix index shall be comprised of 100 percent of the PDPM CMI at full phase in.[~~and zero percent of the RUG-III CMI that was in effect prior to the transition.~~]

Section 8. Limitation on Charges to Residents.

(1) Except for applicable deductible and coinsurance amounts, an NF that receives reimbursement for a resident pursuant to Section 6 of this administrative regulation shall not charge a resident or his representative for the cost of routine or ancillary services.

(2) An NF may charge a resident or his representative for an item pursuant to 42 C.F.R. 483.10(f)(11)(ii) if:

(a) The item is requested by the resident or representative;

(b) The NF informs the resident or representative in writing that there will be a charge; and

(c) Medicare, Medicaid, or another third party does not pay for the item.

(3) An NF shall:

(a) Not require a resident, or responsible representative of the resident, to request any item or services as a condition of admission or continued stay; and

(b) Inform a resident, or responsible representative of the resident, requesting an item or service for which a charge will be made in writing that there will be a charge and the amount of the charge.

(4) Reserved bed days, per resident, for an NF or an NF-W shall be:

(a) Reimbursed for a maximum of thirty (30) days per calendar year due to hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to relocation;

(b) Reimbursed for a maximum of ten (10) days during a calendar year for leaves of absence other than hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to the relocation;

(c) Reimbursed at seventy-five (75) percent of a facility's rate.

(5) Except for oxygen therapy, durable medical equipment (DME) and supplies shall:

(a) Be furnished by an NF; and

(b) Not be billed to the department under a separate DMS claim pursuant to 907 KAR 1:479, Section 6(3).

(6) Except as otherwise covered pursuant to Title 907 KAR, dentures, lenses, frames, or hearing aids shall be paid for through the resident's patient liability or spend down amounts and limited to one (1) replacement per item per calendar year.

Section 9. Reimbursement for Required Services Under the Preadmission Screening Resident Review (PASRR).

(1) Prior to an admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

(2) The department shall reimburse an NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.

(3) Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

Section 10. Price-Based NF Protection Period and Budget Constraints.

(1) A county-owned hospital-based nursing facility shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

(2) For each year of the biennium, a price-based NF shall:

(a) Receive an adjustment pursuant to Section 5(8) and (9) of this administrative regulation; or

(b) Except for a county-owned hospital-based nursing facility pursuant to subsection (1) of this section, not receive an increase if the price-based NF's rate is greater than its standard price.

Section 11. Cost Report.

(1) A Medicare cost report and the Supplemental Medicaid Schedules shall be submitted pursuant to time frames established in the CMS Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-2) Sections 102, 102.1, 102.3, and 104, using the Instructions for Completing the Medicaid Supplemental Schedules.

(2) A copy of a price-based NF's Medicare cost report shall be submitted for the most recent fiscal year end.

Section 12. Ancillary Services.

(1) Except for [~~oxygen therapy and for~~]ancillary services provided to an individual in a critical access hospital swing bed, the department shall reimburse for an ancillary service [~~that meets the criteria established in 907 KAR 1:023~~]utilizing a per diem component to the rates, updated every July 1.

(a) Prior year utilization based on claims through June 30, 2024, and the corresponding outpatient procedure code rate listed in the Medicaid Physician Fee Schedule established in 907 KAR 3:010, Section 1(17). For oxygen therapy procedure codes, the Medicaid DME Program fee schedule established in 907 KAR 1:479 shall be utilized.

(b) For dates of service July 1, 2024, and after, the volume of services shall be reported by the provider on the Kentucky Medicaid Nursing Facility Ancillary Supplemental ***Schedule[~~Schedules~~]***. The schedules on file by the department as of June 1 of each year shall be used to determine the ancillary fees. ***Additional information relating to the completion of supplemental schedules shall be accessed by utilizing the Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules Instructions.***

(c) The sum from paragraphs (a) and (b) ***of this subsection[~~above~~]*** shall be divided by the number of the provider's paid Medicaid days for the same time period.

[~~(2)~~] [~~The department shall reimburse for an oxygen therapy utilizing the Medicaid DME Program fee schedule established in 907 KAR 1:479.~~]

(2)[~~(3)~~] Respiratory therapy and respiratory therapy supplies shall be a routine service.

(3)[~~(4)~~] Reimbursement for ancillary services provided to an individual in a critical access hospital swing bed shall be included in the critical access hospital swing bed reimbursement established in Section 3(2) of this administrative regulation.

Section 13. Quality Program.

(1) Beginning with rates effective July 1, 2025, there shall be a quality add on component in the prospective per diem rates, distributed from a pool of combined funding (state and federal share) from the provider assessment.

(a) For rates effective July 1, 2025, through December 31, 2025, the quality pool shall be five (5) percent of the increase to the provider assessment effective July 1, 2024.

(b) For rates effective January 1, 2026, through June 30, 2026, the quality pool shall be ten (10) percent of the increase to the provider assessment effective July 1, 2024.

(c) For rates effective July 1, 2026, through December 31, 2026, the quality pool shall be fifteen (15) percent of the increase to the provider assessment effective July 1, 2024.

(d) For rates effective January 1, 2027 and after, the quality pool shall be twenty (20) percent of the increase to the provider assessment effective July 1, 2024.

(2) The allowance to offset the provider assessment as determined in Section 5(5)(a) ***of this administrative regulation*** shall be reduced in order to fund the quality pool.

(3) Any leftover funds shall be rolled into the pool for the next state fiscal year.

(4) Points shall be determined on a tiered scoring allocation system, as set by the department, based on metrics from CMS Care Compare, the Supplemental Medicaid Schedules, and the Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement and may be adjusted periodically.

(5) Each metric shall be weighted equally in the collection of total points and distributed by the facility's percentage of weighted Medicaid days.

(6) The quality add on shall be updated on a quarterly basis based on the most recent information as of the day preceding the rate effective date.

Section 14.[~~Section 13.~~] Appeal Rights. A price-based NF may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 15.[~~Section 14.~~] Supplemental Payments to Nonstate Government-Owned or Operated Nursing Facilities.

(1) Beginning July 1, 2001, subject to state funding made available for this provision by a transfer of funds from a governmental entity, the department shall make a supplemental payment to a qualified nursing facility.
(2) To qualify for a supplemental payment under this section, a nursing facility shall:
(a) Be owned or operated by a local unit of government pursuant to 42 C.F.R. 447.272(a)(2);
(b) Have at least 140 or more Medicaid-certified beds; and
(c) Have a Medicaid occupancy rate at or above seventy-five (75) percent.
(3) For each state fiscal year, the department shall calculate the maximum supplemental payment that it may make to qualifying nursing facilities in accordance with 42 C.F.R. 447.272.
(4) Using the data reported by a nursing facility on a Schedule NF-7 submitted to the department as of December 31, 2000, the department shall identify each nursing facility that meets the criteria established in subsection (2) of this section.
(5) The department shall determine a supplemental payment factor for a qualifying nursing facility by dividing the qualifying nursing facility's total Medicaid days by the total Medicaid days for all qualifying nursing facilities.
(6) The department shall determine a supplemental payment for a qualifying nursing facility by applying the supplemental payment factor established in subsection (5) of this section to the total amount available for funding under this section.
(7) Total payments made under this section shall not exceed the amount determined in subsection (3) of this section.
(8) Payments made under this section shall:
(a) Apply to services provided on or after April 1, 2001; and
(b) Be made on a quarterly basis.

Section 16.[~~Section 15.~~] Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 17.[~~Section 16.~~] Incorporation by Reference.
(1) The following material is incorporated by reference:
(a) "Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-2), Sections 102, 102.1, 102.3, and 104", October 2007;
(b) The "Instructions for Completing the Medicaid Supplemental Schedules", April 2015;
(c) The "Supplemental Medicaid Schedules", April 2015;[~~and~~]
(d) The "Kentucky Medicaid Nursing Facility Ancillary Supplemental ***Schedule[~~Schedules~~]***," ***June[~~July~~]*** 2024;
(e) The "Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules Instructions," July 2024;
(f) The "Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement", ***May[~~February~~]*** 2025; and
(g)[~~(d)~~] "***[~~PDPM Adapted~~]***Minimum Data Set (MDS) ***– Version 3.0, Resident Assessment and Care Screening, Nursing Home Comprehensive (NC) Version 1.19.1***", October 1, 2024[~~2023~~].
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the:
(a) Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; and
(b) Following location on the department's website[~~Web site~~]: ***https://www.chfs.ky.gov/agencies/dms/provider/Pages/nursingfacilities.aspx [~~https://chfs.ky.gov/agencies/dms/dafm/Pages/default.aspx~~]***.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6W-A
Frankfort, Kentucky 40621
@chfsky | CHFS.KY.GOV

Steven Stack, MD
SECRETARY

Lisa D. Lee
COMMISSIONER

December 3, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

FILED WITH LRC
TIME: 1:40pm
DEC 03 2025
Emily B Caudill
REGULATIONS COMPILER

907 KAR 8:020. Independent physical therapy service coverage provisions and requirements.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 8:020, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 8:020.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services, at (502) 564-4321, ext. 2015.

Sincerely,

Lucie Estill
Staff Assistant
Office of Legislative and Regulatory Affairs

Subcommittee Substitute

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(Amendment)

907 KAR 8:020. Independent physical therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.622, 369.101-369.120, 42 C.F.R. 431.17, 440.130, 45 C.F.R. Part 164, 42 U.S.C. 1396d(a)(13)(C)
CERTIFICATION STATEMENT:
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding physical therapy services provided by an independent physical therapist or physical therapy assistant working under the direct supervision of an independent physical therapist.

Section 1. Provider Participation.
(1)
(a) To be eligible to provide and be reimbursed for physical therapy as an independent provider, a provider shall be:
1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;
2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and
3. Except as provided in subsection (2) of this section, a physical therapist.
(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid program.
(2) Physical therapy provided in accordance with Section 2 of this administrative regulation by a physical therapist assistant who works under the direct supervision of a physical therapist who meets the requirements in subsection (1) of this section shall be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Coverage and Limit.
(1) The department shall reimburse for physical therapy if:
(a) The therapy:
1. Is provided:
a. By a:
(i) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Physical therapist assistant who works under the direct supervision of a physical therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level; and

3. [~~Is prior authorized; and~~]

[~~4.~~] Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)

(a) There shall be an annual limit of twenty (20) physical therapy visits per recipient per calendar year except as established in [~~paragraph (b) of~~]this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department, if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

(c) Prior authorization by the department shall be required only for each therapy visit that exceeds the limit established in paragraph (a) of this subsection unless[~~for a recipient who is not enrolled with~~] a managed care organization establishes a higher limit contractually with the provider.

(d) The limit established in paragraph (a) of this subsection shall not apply to the list of diagnoses established in this paragraph. The therapy diagnosis codes referenced are for information purposes only and shall be updated, if necessary, by the department on an annual basis on any relevant fee schedules. These therapy diagnoses and diagnosis codes shall not be subject to a prior authorization requirement after meeting the visit limit in paragraph (a) of this subsection:

1. Cerebral palsy, currently referenced ***by [~~via~~]*** diagnosis code G80;

2. Amytrophic lateral sclerosis (ALS), currently referenced ***by [~~via~~]*** diagnosis code G12;

3. Spinal muscular atrophy (SMA), currently referenced ***by [~~via~~]*** diagnosis code G12;

4. Muscular dystrophy, currently referenced ***by [~~via~~]*** diagnosis code G71;

5. Multiple sclerosis, currently referenced ***by [~~via~~]*** diagnosis code G35;

6. Any traumatic brain injury currently referenced ***by [~~via~~]*** diagnosis code S06;

7. Parkinson's, currently referenced ***by [~~via~~]*** diagnosis code G20;

8. Alzheimer's disease, currently referenced ***by [~~via~~]*** diagnosis code G30;

9. Dementia, currently referenced ***by [~~via~~]*** diagnosis codes F01 to F03;

10. Frontotemporal dementia, currently referenced by diagnosis code G31;

11. Any intellectual disability currently referenced by diagnosis codes F70 to F79;

12. Ankylosing spondylitis, currently referenced by diagnosis code M45.9; or

13. Diffuse idiopathic skeletal hyperostosis (DISH), currently referenced by diagnosis code M48.1.

Section 3. No Duplication of Service.

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

(2) For example, if a recipient is receiving physical therapy from a physical therapist enrolled with the Medicaid program, the department shall not reimburse for physical therapy provided to the same recipient during the same time period ***by [~~via~~]*** the home health program.

Section 4. Records Maintenance, Protection, and Security.

(1)

(a) A provider shall maintain a current health record for each recipient;

(b)

1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service; and

2. The individual who provided the service shall date and sign the health record within seventy-two (72) hours of[~~on~~] the date that the individual provided the service.

(2)

(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least seven (7)[~~five (5)~~] years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years; and

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

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

Section 5. Medicaid Program Participation Compliance.

(1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)

(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

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

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Use of Electronic Signatures.

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

(2) A provider that chooses to use electronic signatures shall:

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

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:
1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

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

Section 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights.
(1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.
(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6W-A
Frankfort, Kentucky 40621
@chfsky | CHFS.KY.GOV

Steven Stack, MD
SECRETARY

Lisa D. Lee
COMMISSIONER

December 3, 2025

FILED WITH LRC
TIME: 1:40pm
DEC 03 2025
Emily B Caudill
REGULATIONS COMPILER

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 8:040. Coverage of occupational therapy, physical therapy, and speech-language pathology services provided by various entities.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 8:040, the Department for Medicaid Services proposes the attached suggested substitute to 907 KAR 8:040.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Office of Legislative and Regulatory Affairs
Cabinet for Health and Family Services

Subcommittee Substitute

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(Amendment)

907 KAR 8:040. Coverage of occupational therapy, physical therapy, and speech-language pathology services provided by various entities.

RELATES TO: KRS 205.520, 205.622, 369.101-369.120, 42 C.F.R. 431.17, 440.130, 45 C.F.R. Part 164, 42 U.S.C. 1396a(a)(30)
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(30)
CERTIFICATION STATEMENT:
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding occupational therapy services, physical therapy services, and speech-language pathology services provided by adult day health care programs, rehabilitation agencies, special health clinics, mobile health services, multi-therapy agencies, and comprehensive outpatient rehabilitation facilities to Medicaid recipients.

Section 1. Provider Participation. To be eligible to provide and be reimbursed for services covered under this administrative regulation, a provider shall be:
(1) Currently enrolled in the Kentucky Medicaid program in accordance with 907 KAR 1:672;
(2) Currently participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671; and
(3)
(a) An adult day health care program;
(b) A multi-therapy agency;
(c) A comprehensive outpatient rehabilitation facility;
(d) A mobile health service;
(e) A special health clinic; or
(f) A rehabilitation agency.

Section 2. Coverage of Services.
(1) The services covered under this administrative regulation shall include:
(a) Physical therapy;
(b) Occupational therapy; or
(c) Speech-language pathology services.
(2) To be covered under this administrative regulation, a service shall be:
(a) Provided to a recipient;
(b) Provided by:

1. An occupational therapist who renders services on behalf of a provider listed in Section 1(3) of this administrative regulation;

2. A physical therapist who renders services on behalf of a provider listed in Section 1(3) of this administrative regulation;

3. A speech-language pathologist who renders services on behalf of a provider listed in Section 1(3) of this administrative regulation;

4. An occupational therapy assistant who renders services:

a. Under supervision in accordance with 201 KAR 28:130; and

b. On behalf of a provider listed in Section 1(3) of this administrative regulation; or

5. A physical therapist assistant who renders services:

a. Under supervision in accordance with 201 KAR 22:053; and

b. On behalf of a provider listed in Section 1(3) of this administrative regulation;

(c) Ordered by:

1. A physician currently participating in the Medicaid program in accordance with 907 KAR 1:671;

2. An advanced practice registered nurse currently participating in the Medicaid program in accordance with 907 KAR 1:671;

3. A physician assistant currently participating in the Medicaid program in accordance with 907 KAR 1:671; or

4. A psychiatrist currently participating in the Medicaid program in accordance with 907 KAR 1:671;

(d) Consistent with a plan of care that shall:

1. Be developed:

a. By:

(i) An occupational therapist currently participating in the Medicaid program in accordance with 907 KAR 1:671;

(ii) A physical therapist currently participating in the Medicaid program in accordance with 907 KAR 1:671; or

(iii) A speech-language pathologist currently participating in the Medicaid program in accordance with 907 KAR 1:671; and

b. In collaboration with:

(i) A physician currently participating in the Medicaid program in accordance with 907 KAR 1:671;

(ii) An advanced practice registered nurse currently participating in the Medicaid program in accordance with 907 KAR 1:671;

(iii) A physician assistant currently participating in the Medicaid program in accordance with 907 KAR 1:671; or

(iv) A psychiatrist currently participating in the Medicaid program in accordance with 907 KAR 1:671; and

2. Identify a specific amount and duration;

(e) For the:

1. Maximum reduction of the effects of a physical or intellectual disability; or

2. Restoration of a recipient to the recipient's best possible functioning level; and

(f) Medically necessary.

(3)

(a) There shall be an annual limit of twenty (20) rehabilitative visits and an annual limit of twenty (20) habilitative visits for each of the following:

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (c) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (c) of this subsection; and

3. Speech-language pathology service visits per recipient per calendar year except as established in paragraph (c) of this subsection.

(b) For example, a recipient may receive twenty (20) rehabilitative occupational therapy visits, twenty (20) rehabilitative physical therapy visits, and twenty (20) rehabilitative speech-language pathology service visits per calendar year and in the same calendar year, a recipient may receive twenty (20) habilitative occupational therapy visits, twenty (20) habilitative physical therapy visits, and twenty (20) habilitative speech-language pathology service visits.

(c) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department, if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

(d) Medical necessity shall be determined on an individual basis per recipient based on the given recipient's needs.

(e) Prior authorization by the department shall be required only for visits above the limit established in paragraph (a) of this subsection unless[~~for a recipient who is not enrolled with~~] a managed care organization establishes a higher limit contractually with the provider.

(f) The limit established in paragraph (a) of this subsection shall not apply to the list of diagnoses established in this paragraph. The therapy diagnosis codes referenced are for information purposes only, and shall be updated – if necessary – by the department on an annual basis on any relevant fee schedules. These therapy diagnoses and diagnosis codes shall not be subject to a prior authorization requirement after meeting ***the visit limits in paragraph (a) of this subsection [~~paragraph (a)'s visit limit~~]***:

1. Cerebral palsy, currently referenced ***by [~~via~~]*** diagnosis code G80;

2. Amytrophic lateral sclerosis (ALS), currently referenced ***by [~~via~~]*** diagnosis code G12;

3. Spinal muscular atrophy (SMA), currently referenced ***by [~~via~~]*** diagnosis code G12;

4. Muscular dystrophy, currently referenced ***by [~~via~~]*** diagnosis code G71;

5. Multiple sclerosis, currently referenced ***by [~~via~~]*** diagnosis code G35;

6. Any traumatic brain injury currently referenced ***by [~~via~~]*** diagnosis code S06;

7. Parkinson's, currently referenced ***by [~~via~~]*** diagnosis code G20;

8. Alzheimer's disease, currently referenced ***by [~~via~~]*** diagnosis code G30;

9. Dementia, currently referenced ***by [~~via~~]*** diagnosis codes F01 to F03;

10. Frontotemporal dementia, currently referenced by diagnosis code G31;

11. Intellectual disabilities, currently referenced by diagnosis codes F70 to F79;

12. Ankylosing spondylitis, currently referenced by diagnosis code M45.9; or

13. Diffuse idiopathic skeletal hyperostosis (DISH), currently referenced by diagnosis code M48.1.

Section 3. Documentation, Records Maintenance, Protection, and Security.

(1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Document the provider's initial assessment of the recipient and any subsequent assessments;

(b) Document each service provided to the recipient; and

(c) Include detailed staff notes that state:

1. Progress made toward outcomes identified according to the provider's assessment and in the plan of care developed pursuant to Section 2(2)(d) of this administrative regulation;
2. The date of each service;
3. The beginning and ending time of each service; and
4. The signature and title of the individual providing each service.

(3) The individual who provides a service shall date and sign the health record within seventy-two (72)[~~forty-eight (48)~~] hours of the date that the individual provides the service.

(4)

(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

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

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

Section 4. Medicaid Program Participation Compliance.

(1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) [~~KAR Title 895; and~~]

[~~(d)~~] All applicable state and federal laws.

(2)

(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department in accordance with 907 KAR 1:671.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 5. No Duplication of Service.

(1) The department shall not reimburse for an occupational therapy service, physical therapy service, or speech-language pathology service provided to a recipient by more than one (1) provider of any Medicaid program in which the respective service is covered during the same time period.

(2) For example, if a recipient is receiving an occupational therapy service from a multi-therapy agency enrolled with the Medicaid program, the department shall not reimburse for the same occupational therapy service provided to the same recipient during the same time period ***by*** ***~~[via]~~*** the home health program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Out-of-State Providers. The department shall cover a service under this administrative regulation that is provided by an out-of-state provider if the:

(1) Service meets the coverage requirements of this administrative regulation; and

(2) Provider:

(a) Complies with the requirements of this administrative regulation; and

(b) Is:

1.

a. Licensed as an adult day health care program in the state in which it is located;

b. A comprehensive outpatient rehabilitation facility licensed in the state in which it is located;

c. Licensed as a mobile health service in the state in which it is located;

d. A special health clinic licensed in the state in which it is located;

e. A rehabilitation agency licensed in the state in which it is located;

f. An occupational therapist or occupational therapist group;

g. A physical therapist or physical therapist group;

h. A speech-language pathologist or speech-language pathologist group; or

i. A multi-therapy agency;

2. Currently enrolled in the Kentucky Medicaid program in accordance with 907 KAR 1:672; and

3. Currently participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

Section 8. Use of Electronic Signatures.

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

(2) A provider that chooses to use electronic signatures shall:

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

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

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

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

(b) Develop a consent form that shall:

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

2. Attest to the signature's authenticity; and

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

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

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and
3. The original filed signature.

Section 9. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 10. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 11. Appeals.
(1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.
(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.