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 via diagnosis code G80;

2. Amytrophic lateral sclerosis (ALS), currently referenced via diagnosis code G12;

3. Spinal muscular atrophy (SMA), currently referenced via diagnosis code G12;

4. Muscular dystrophy, currently referenced via diagnosis code G71;

5. Multiple sclerosis, currently referenced via diagnosis code G35;

6. Any traumatic brain injury currently referenced via diagnosis code S06;

7. Parkinson's, currently referenced via diagnosis code G20;

8. Alzheimer's disease, currently referenced via diagnosis code G30;

9. Dementia, currently referenced 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 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.

COMPILER'S NOTE: 2025 RS HB 6, enacted by the General Assembly on March 27, 2025, altered the information to be provided at the time an administrative regulation is filed. Aside from formatting changes necessary to upload the regulation into the LRC's publication application, this regulation has been published as submitted by the agency.

LISA D. LEE, Commissioner
STEVEN J. STACK, MD, MBA, Secretary

APPROVED BY AGENCY: August 1, 2025

FILED WITH LRC: September 9, 2025 at 10:09 a.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on November 24, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by November 17, 2025, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation through November 30, 2025. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Krista Quarles and Jonathan Scott

Subject Headings:Brain Injury; Children and Minors; Cognitive Decline and Impairment; Disability and Disabilities; Health and Medical Services; Health Benefit Plans; Health Insurance; Medicaid; Physicians and Practitioners

(1) Provide a brief summary of:

(a) What this administrative regulation does:

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.

(b) The necessity of this administrative regulation:

This administrative regulation is necessary to establish 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.

(c) How this administrative regulation conforms to the content of the authorizing statutes:

This administrative regulation conforms to the content of the authorizing statutes by establishing 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.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:

This administrative regulation assists with the effective administration of the statutes by establishing 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.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation:

The amendment will change this administrative regulation by limiting prior authorization by the department to only therapy visits that exceed the limits established in the administrative regulation unless there is a higher contractual limit established between the provider and the managed care organization. In addition, a list of diagnoses is included that will not be subject to the 20 visit limit. Finally, a date of service signature requirement is removed and replaced with a requirement to sign and date a health record within 72 hours of service.

(b) The necessity of the amendment to this administrative regulation:

The amendment to this administrative regulation is necessary to clarify policies regarding prior authorizations and signature requirements.

(c) How the amendment conforms to the content of the authorizing statutes:

This amendment conforms to the content of the authorizing statute by ensuring there is policy in place regarding prior authorization for therapy services.

(d) How the amendment will assist in the effective administration of the statutes:
This amendment assists with the effective administration of the statutes by ensuring there is policy in place regarding prior authorization for therapy services.

(3) Does this administrative regulation or amendment implement legislation from the previous five years?No.

(4) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
DMS estimates that more than 1,000 practicing and enrolled physical therapists may be affected by this administrative regulation.

(5) Provide an analysis of how the entities identified in question (4) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (4) will have to take to comply with this administrative regulation or amendment:
Therapy providers will be required to comply with the updated prior authorization requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (4):
DMS does not anticipate additional costs as a result of this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (4):
Therapists will only be required to follow the prior authorization policy if the limits established in the administrative regulation are exceeded or if they have a contractual agreement with a managed care organization. This may reduce their administrative burden.

(6) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially:
DMS does not anticipate additional costs as a result of this amendment.

(b) On a continuing basis:
DMS does not anticipate additional costs as a result of this amendment on a continuing basis.

(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation or this amendment:
Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(8) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:
This administrative regulation will not require an increase in fees or funding.

(9) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

This administrative regulation neither establishes nor increases any fees.

(10) TIERING: Is tiering applied?

Tiering is not applied.

FISCAL IMPACT STATEMENT

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation.

KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

(2) Identify the promulgating agency and any other affected state units, parts, or divisions:

Cabinet for Health and Family Services, Department for Medicaid Services, Division of Health Care Policy

(a) Estimate the following for the first year:

Expenditures:DMS does not anticipate additional expenditures as a result of this amendment.

Revenues:DMS does not anticipate additional revenues as a result of this amendment.

Cost Savings:DMS does not anticipate cost savings as a result of this amendment.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS does not anticipate additional expenditures, revenues, or costs savings as a result of this amendment in subsequent years.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts):

N/A

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

N/A

(4) Identify additional regulated entities not listed in questions (2) or (3):

Physical therapy providers.

(a) Estimate the following for the first year:

Expenditures:DMS does not anticipate additional expenditures as a result of this amendment.

Revenues:DMS does not anticipate additional revenues as a result of this amendment.

Cost Savings:DMS does not anticipate cost savings as a result of this amendment.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS does not anticipate additional expenditures, revenues, or costs savings as a result of this amendment in subsequent years.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(b) Methodology and resources used to determine the fiscal impact:
Departmental staff have reviewed and assessed this amendment for fiscal impact.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). ($500,000 or more, in aggregate)
This administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion:
Departmental staff assessing the practice needs of physical therapists.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.
42 U.S.C. 1396d(a)(13)(C)

(2) State compliance standards.
KRS 205.520(3)

(3) Minimum or uniform standards contained in the federal mandate.
42 C.F.R. Part 440, Subpart A establishes requirements for physical therapy, occupations therapy, and services for individuals with speech, hearing, and language disorders.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
The administrative regulation does not impose stricter than federal requirements.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
The administrative regulation does not impose stricter than federal requirements.