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 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 paragraph (a)'s visit limit:

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. 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) 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) 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 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.

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.

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