CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(Amended at ARRS Committee)

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 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 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 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 diagnosis code G80;

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

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

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

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

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

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

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

9. Dementia, currently referenced by 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 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 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) 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.

(907 KAR 008:020. 40 Ky.R. 2045; 2767; eff. 7-7-2014; Crt eff. 12-6-2019; 52 Ky.R. 642, 1144; eff. 1-22-2026.) 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.

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