

# KENTUCKY

Cabinet for Health and Family Services

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SCL TRANSITION WEBINAR  
ON PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY  
FEBRUARY 15, 2017

# What's Changing?

1

CMS is requiring Kentucky Medicaid to transition **physical and occupational therapy and speech-language pathology services** from the HCBS waivers into the state plan.

2

This transition is targeted for **March 15, 2017 for the SCL waiver.**

3

Once the **SCL renewal is approved by CMS** and the therapy transition takes place, the revised SCL regulation will be implemented.

# What's Changing?

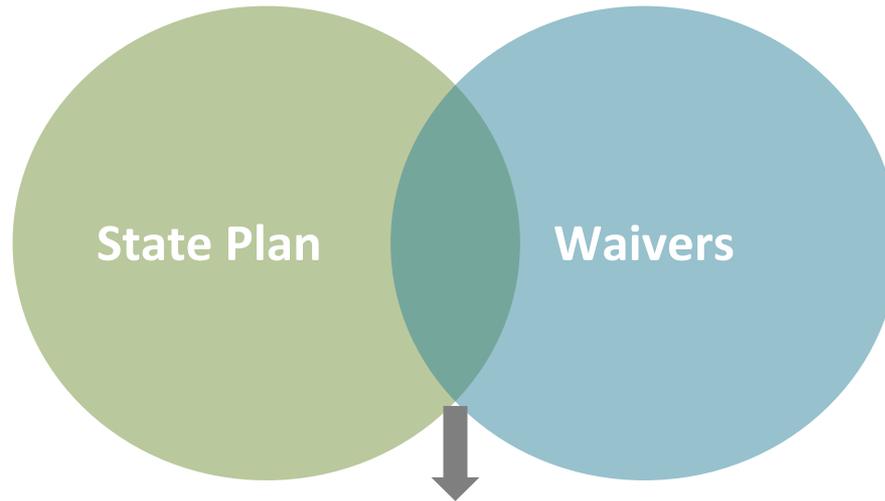
## Overview of Infrastructure Changes to Support Therapy Transition



*\*Licensed organizations include: rehabilitation agencies, mobile health services, special health clinics, multi-specialty therapy groups, and community mental health centers*

# Why are Waiver Services Changing?

PT/OT/ST have been historically provided to Supports for Community Living (SCL) waiver participants as covered services in the 1915(c) waiver. However, on 1/1/14, DMS added PT/OT/ST as covered benefits to its state plan for all Medicaid members.



- Overlap between a service provided in a state plan and a service provided in a 1915(c) HCBS waiver is **not** allowed by the Centers for Medicare and Medicaid Services (CMS).
- Kentucky worked with CMS for several months trying to identify a way to implement a differential rate for providers rendering PT/OT/ST to waiver participants, but CMS informed Kentucky that a differential rate is not possible.
- These services will be reimbursed at the same rate as the existing PT/OT/ST Medicaid fee schedule.

# Communications and Resources

DMS began notifying participants, providers, and case managers about the upcoming change in March 2016, and will continue to communicate closely with providers through the remainder of the transition.

Formal Communications	Participants	<b>March 2016</b> <ul style="list-style-type: none"><li>Letter distributed to all HCBS waiver participants</li></ul>
	Providers	<b>March 2016</b> <ul style="list-style-type: none"><li>SCL provider letter # A-44 distributed</li><li>ADHC provider letter # A-46 distributed</li></ul> <b>December 2016</b> <ul style="list-style-type: none"><li>SCL provider letter # A-46 distributed</li></ul> <b>February 2017</b> <ul style="list-style-type: none"><li>SCL provider letter #A-47 (notification of transition date)</li></ul>
	Case Managers	<b>May 2016</b> <ul style="list-style-type: none"><li>SCL case manager provider letter # A-45 distributed</li><li>ADHC case manager provider letter # A-48 distributed</li></ul> <b>February 2017</b> <ul style="list-style-type: none"><li>SCL provider letter #A-47 (notification of case manager responsibilities)</li></ul>

PT/OT/ST waiver transition frequently asked questions (FAQ)s are available on the Kentucky DMS webpage: <http://www.chfs.ky.gov/dms>

# Case Manager Responsibilities

Case managers play a key role in assuring that individuals will continue to receive PT/OT/ST without interruption during the transition.

## Identify Affected Individuals

### Plan for transition

- Case managers must identify individuals who currently receive PT/OT/ST through the SCL waiver

## Confirm State Plan-enrolled Provider

### Determine next steps

- Confirm that the providers who render therapy services to their individuals will provide therapy services under the State Plan
- If an individual's current provider does not intend to enroll as a State Plan provider, the case manager must identify a new provider to render these services to the individual and assure that the individual can receive services from this new provider by March

## Complete Transition

### Transition services

- Amend the person-centered service plan to remove any PT/ST/OT therapies from waiver services and insert them as State Plan services

# Additional Resources

The following are additional resources you may access related to the transition:

- DMS provider directory: <http://www.kymmis.com/Provider%20Directory/default.aspx>
  - Provider Type 76, Multi-therapy agency
  - Provider Type 79, Speech-language pathologist
  - Provider Type 87, Physical therapist
  - Provider Type 88, Occupational therapist
  - Provider Type 30, Community mental health center
- Therapy Transition prior authorization forms, instructions, and Therapy Transition FAQs: <http://www.chfs.ky.gov/dms/>

# Appendix

# Provider Enrollment Steps

Waiver providers who render PT/OT/ST should enroll as Medicaid state plan providers now to ensure consistency of services for participants.

## Step One:

- <http://chfs.ky.gov/dms/provEnr/>
- Select Provider Type Summaries

**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

■ About CHFS | Contact Us | Forms and Documents | Información en Español  
■ Home > Department for Medicaid Services > Provider Enrollment > Overview

### Provider Enrollment

Welcome to the Kentucky Medicaid provider enrollment website

Thank you for participating in the Kentucky Medicaid Program. The Kentucky Medicaid Program appreciates your interest and welcomes the opportunity to work with you to provide health care services to Kentucky Medicaid members.

- If you want to learn about KY Medicaid Provider, refer to [What is a KY Medicaid Provider?](#)
- If you are a new provider, refer to the [Application Information](#) and [Provider Type Summaries](#).
- If you are an existing provider and need to make changes, refer to [Maintenance Information](#).
- If you need to update your License, refer to [Update Your License Information with KY Medicaid](#)
- [Read provider enrollment updates](#) **New Information**

If you have any further questions or need assistance, please either [email](#) us or call toll free: 877-838-5085 Monday to Friday 8 a.m. - 4:30 p.m. ET.

**Note:** Please read the [Important Provider Enrollment Information](#) regarding new phone hours and email address.

#### Provider Enrollment Updates

##### Attention Providers

(May 28, 2015) - Starting **July 1st** providers **will no longer** be required to file an **Annual Disclosure of**

**Provider Enrollment Resources**

- [Department for Medicaid Services](#)
- [Kentucky Medicaid Provider Directory](#)
- [DMS Provider Letter Home](#)

**Regulations, Publications, Termed Provider List**

#### Regulations

- 907 KAR 1:671
- 907 KAR 1:672

#### Publications

- [Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse](#)

**Contact Information**

Kentucky Department for Medicaid Services  
Provider Enrollment  
P.O. Box 2110  
Frankfort, KY 40602  
**Toll free:** (877) 838-5085  
Monday to Friday  
8 a.m. - 4:30 p.m. ET

**Email**  
For other questions or

**Navigation Menu:**  
National Provider Identifier (NPI)  
Provider Revalidation  
Application Information  
Archived Provider Enrollment Notices  
FAQ  
Forms  
Maintenance Information  
Managed Care Organization Information  
Overview  
**Provider Type Summaries**

Subscribe to the new Provider Enrollment Listserv  
If you are interested in receiving e-mail notices on Provider Enrollment, click [here](#) to add or delete subscriptions at any time.

DMS is expediting enrollment of providers related to the therapy transition. Please contact Kate Hackett or Sapna Sairajeev at 502-564-1013 if you have not been enrolled after 30 days of receipt.

# Provider Enrollment Steps

Required forms for enrollment may vary among provider types. It is important to select the correct provider type to ensure that you have the right information to enroll as that provider type.

## Step Two:

- Browse the 'Current Provider Number and Type' for your provider type:
  - 76: Multi-Therapy Agency\***
  - 79: Speech Language Pathologist**
  - 87: Physical Therapist**
  - 88: Occupational Therapist**
- Click on the appropriate provider type to determine what forms are required for enrollment

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DEPARTMENT FOR MEDICAID SERVICES

■ About CHFS | Contact Us | Forms and Documents | Información en Español  
■ Home > Department for Medicaid Services > Provider Enrollment > **Provider Type Summaries**

**Provider Type Summaries**

**Welcome**

Please select the provider type from the list below for application information.

If you have any questions on the information provided for the provider types below, contact Provider Enrollment from 8 a.m. - 4:30 p.m. ET Monday through Friday at (877) 838-5085.

The free [Adobe Acrobat Reader](#) is required to view and print these documents.

**Current Provider Number and Type**

- 01 - [Hospital](#)
- 02 - [Psychiatric Hospital](#)
- 03 - [Behavioral Health Service Organization \(BHSO\)](#)
- 04 - [Psychiatric Residential Treatment Facility \(PRTF\)](#)
- 05 - [Psychiatric Residential Treatment Facility \(PRTF\) Level II](#)
- 10 - [Intermediate Care Facility - Individuals with Intellectual Disability \(ICF/IID\) Clinic](#)
- 11 - [Intermediate Care Facility for Individuals with Intellectual Disabilities \(ICF/IID\)](#)
- 12 - [Nursing Facility](#)
- 13 - [Specialized Children's Services Clinic](#)
- 15 - [Health Access Nurturing Development Services \(HANDS\)](#)
- 17 - [Acquired Brain Injury](#)
- 18 - [Private Duty Nursing](#)
- 20 - [Preventive and Remedial Public Health Services](#)
- 21 - [School Based Services](#)
- 22 - [Commission For Children with Special Health Care Needs](#)
- 23 - [Targeted Case Management and Rehabilitative](#)

**Policy Information**  
Use of 71 Provider number (Sept. 7, 2007)

**Contact Information**  
Kentucky Department for Medicaid Services  
Provider Enrollment  
P.O. Box 2110  
Frankfort, KY 40602  
**Toll free:** (877) 838-5085  
Monday to Friday  
8 a.m. - 4:30 p.m. ET

**Email**  
For other questions or assistance, e-mail the [CHFS DMS Webmaster](#)

# Provider Enrollment Steps

Each provider type summary details the provider requirements and necessary forms that must be completed for enrollment.

## Step Three:

- Review the provider type summary to ensure that you meet the enrollment requirements
- Identify which forms you will be required to complete

**TENTATIVE\***  
**SUBJECT TO CHANGE PENDING CMS APPROVAL  
AND ADOPTION OF NEW REGULATIONS**

Multi-Therapy Agency  
Provider Type 76

Information about the program:

- Provider must be an entity licensed (unless exempt from licensure) by the state where they practice.
- Provider must be providing one or a combination of the following: physical therapy, occupational therapy and/or speech language pathology.
- Out-of-state providers may enroll.
- Providers must have "bricks and mortar."

Additional Information to be submitted by the provider for application processing:

- MAP-811
- MAP-811 Addendum E
- MAP-347 for all licensed providers within the group. (Individual provider number **must** be active in order to join a group.)
- License (unless exempt from licensure) for one of the following: Adult Day Health, Special Health Services Clinic, Rehabilitation Agency or a Mobile Health Services.
- If a provider is exempt from licensure, must submit a letter indicating why the provider is exempt.
- CLIA Certificate (if applicable)
- IRS letter of verification of FEIN or Official IRS documentation stating FEIN. FEIN must be pre-printed by IRS on documentation. W-9 forms will not be accepted.
- NPI and Taxonomy Verification

Important addresses:

- KY Medicaid  
Provider Enrollment  
P.O. Box 2110  
Frankfort, KY 40602

# Provider Enrollment Steps

All Medicaid forms required for enrollment are available on the DMS webpage for download.

## Step Four:

- Select 'Forms'
- View each form that is required based upon the provider type summary

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DEPARTMENT FOR MEDICAID SERVICES

■ About CHFS | Contact Us | Forms and Documents | Información en Español  
■ Home > Department for Medicaid Services > Provider Enrollment > **Forms**

**Kentucky**  
UNBROKEN SPIRIT

**Forms**

Welcome to the Kentucky Department of Medicaid Services Provider Enrollment Forms webpage.

If you are a new provider, refer to the [enrollment forms](#) listed below.

If you are an existing provider and need to make changes, refer to the [maintenance forms](#) listed below.

**Attention Providers - MAP-811 form launch delayed**

(May 5, 2015) - An April 26, 2015 letter sent to providers regarding 2015 legislative changes to provider enrollment included the statement, "In addition, effective May 1, 2015, all applications must be submitted on the revised MAP-811 in order to be processed. Otherwise, the application will be returned."

**Due to technical difficulties launching the new MAP-811 form, DMS advises providers this change will not take effect until July 1, 2015.** You may submit either version of the MAP 811 application until July 1, 2015.

**Enrollment Forms**

- [MAP- 811 \(Enrollment\)](#) (rev. May 2015) **New** (with [MAP- 811 Addendum E](#) - Direct Deposit Authorization/Cancellation Form - and verification of bank account/routing number such as voided check or bank letter if provider chooses to enroll in direct deposit)
- [MAP-900 \(Revalidation\)](#) (rev. May 2015) **New**
- [Map 347](#) - Statement for Authorization of Payment [MAP-347 Group Linkages](#) **New**
- [MAP 572A](#) - Private Auto Provider
- [Map 572B](#) - Foster Parent Provider Agreement
- [MAP-612](#) - Statement for Authorization of Payment (Physician Assistant)

**Contact Information**

Kentucky Department for Medicaid Services  
Provider Enrollment  
P.O. Box 2110  
Frankfort, KY 40602  
**Toll free:** 877-838-5085  
Monday to Friday  
8 a.m. - 4:30 p.m. EST

**Email**

For questions regarding this website, e-mail the CHFS DMS Webmaster.

# Provider Enrollment Steps

The MAP-811 is a required form for all therapy provider types.

## Step Five:

- Complete the necessary forms
- Submit the forms to Kentucky Medicaid or the MCO with which you are enrolling

**Map-811 Checklist**

**NOTICE:** Pursuant to 907 KAR 1:672, Section 2 1(c) (1), you must be enrolled as a provider to be eligible to receive reimbursement. Enrollment in the program is not a guarantee; Kentucky Medicaid members prior to your effective date is at your own financial risk.

A complete list of enrollment requirements for each provider type can be found at the following link: <http://www.chfs.ky.gov/dms/provEnr/Provider-Type-Summaries.htm>

Did you:

- ◆ Complete *all* questions? Questions not applicable should be completed with "N/A" (*Applications will be rejected for any questions left blank.*)
- ◆ Sign and date signature page (page 12) *Electronic or stamped signatures are not acceptable.*
- ◆ Attach appropriate licenses and/or certifications and all other required documents as current?
- ◆ Attach verification documentation for NPI and Taxonomy Code(s) from CMS NP
- ◆ Attach a **MAP-347** if individual wants to be linked to group KY Medicaid provider
- ◆ Attach a copy of your Social Security card if you are enrolling as an individual. If you are applying with a FEIN.
- ◆ If you are subject to an application fee, please attach a check payable to the KY State Treasurer. For information on the application fee, please refer to your Provider Type Summary at <http://www.chfs.ky.gov/dms/provEnr/Provider-Type-Summaries.htm>.
- ◆ Keep a copy of the application for your records.

Not completing these reminders will delay the processing of your application. Please complete. Other information not mentioned above may be requested during the processing of your application.

If you are completing this application for ENROLLMENT and you will not be participating in the program, please send this application to the following address:

Kentucky Medicaid  
P.O. Box 2110  
Frankfort, KY 40602

If you are completing this application for ENROLLMENT and you will be participating in the program, you need to submit this application to the MCO of your choice.

Please do not send the application directly to the Department for Medicaid Services for processing of your application.

If you have any questions regarding your enrollment, please call Kentucky Medicaid at 1-800-368-8888. A provider enrollment specialist will be available to help you between the hours of 8 am and 5 pm, Monday through Friday.

Map-811 (Enrollment)  
(Rev. 7/2015)

**For Kentucky Medicaid Use Only:**  
ATN# \_\_\_\_\_  
Identifier \_\_\_\_\_  
Provider Type \_\_\_\_\_  
Reviewer's Initials \_\_\_\_\_

**COMMONWEALTH OF KENTUCKY  
DEPARTMENT FOR MEDICAID SERVICES  
SECTION A: ADMINISTRATIVE INFORMATION**

I am enrolling as a:  New Provider  Re-applicant  Change of Ownership  Reinstatement

Will you be contracting with a KY Managed Care organization (MCO)?  Yes  No *If yes, please indicate which MCO?*  
 Anthem  Coventry Cares of Kentucky  Humana CareSource  Passport Health Plan  WellCare of Kentucky

1. Kentucky Medicaid Provider Number: \_\_\_\_\_  Check here for N/A  
(Complete only if you have indicated Reapplicant, or Reinstatement above.)

2. Applying As:  
Please check only one box and print clearly. For individual applicants, please input any suffixes if applicable.  
 Individual  Entity  Group

3. Doing Business As (DBA): \_\_\_\_\_

4. Please select:  Public  Private  Non-Profit

5. Please select:  Profit  Non-Profit

6. License/Certification #: \_\_\_\_\_

7. Provider Type: \_\_\_\_\_

8. Type of Service: \_\_\_\_\_

9. Date Provider Request: Effective Enrollment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date must be in mm/dd/yyyy format)

10. National Provider Identifier (NPI): \_\_\_\_\_

11. Primary Taxonomy Code: \_\_\_\_\_  
(Attach extra sheet if necessary.)

12. SSN: \_\_\_\_\_

13. FEIN (Please list only if you own the FEIN 100%). \_\_\_\_\_

14. Date of Birth: \_\_\_\_\_

15. DMS will report all monies paid to the IRS. Please indicate which number you use for tax reporting. (If you are enrolling as an individual and do not own a FEIN, please check SSN field.) (Check one only.)  SSN  FEIN

16. Tax Structure: Please select only one structure.  
 Individual  Partnership  Corporation  Government/Non-Profit  
 Sole Proprietor  Estate/Trust  Public Service Corporation  Limited Liability Company

17. Agent of Service in Case of Summons (N/A not acceptable). \_\_\_\_\_

18. Telephone # of Agent of Service (N/A not acceptable). \_\_\_\_\_

19. PRIMARY PHYSICAL BUSINESS LOCATION:  
(If you have more than one physical location, attach a copy of items listing additional locations. If an entity/group is applying, each additional location may require separate enrollment.)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax #: \_\_\_\_\_ County: \_\_\_\_\_

20. MAILING ADDRESS:  (Check here if same as primary physical business address)  
 Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Credentialing Contact Information (Required)**  
(This individual will be contacted should any information be needed to process the application.) Note: Your email address will not be given to any outside party for any reason. DMS may use provider email addresses to send provider letters/notices.

Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

21. PAY-TO/1099 ADDRESS:  (Check here if same as primary physical business address)  
 Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Contact Last Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

22. List any Kentucky Medicaid group/facility numbers you have held in the past three years.  Check here for N/A

23. Please list all Medicare Provider Numbers. (Attach extra sheet if necessary.)  Check here for N/A

Fill out all Applicable Sections. Write Not Applicable (N/A) for questions that do not apply. Applications will be rejected for any questions left blank. Please print or type. Reformatted or altered applications will not be accepted.

- 1 -

# Provider Enrollment Guidance

The following information will assist in having a smooth and quick enrollment. It is important to know that if you are currently serving active waiver participants, waiver participants are **not** enrolled in Managed Care, and therefore, as their provider, you will need to enroll as a Medicaid provider.

## ANSWER ALL QUESTIONS ON THE FORM!

- If the question does not apply, be sure to indicate **“N/A”**. Many of the questions do not apply to an individual.
- Do not answer a question and check “N/A”.
- DMS cannot assume the answer. It must be complete.
- Clock starts with a correct and complete application.

## Common Issues:

- Ensure the **entire legal name** is entered – no initials.
- Ensure the provider number listed is the **Medicaid provider number** for the provider that the form pertains to.
- Do not put NPI or Tax ID if it asks for Medicaid provider number.
- If an **attachment** is needed, make sure the **attachment** is **clearly labeled** with the question number and the **question** indicates **“see attached”**.
- Ensure the correct **taxonomy** is listed.
- **Sign the form.**

# Provider Enrollment Guidance

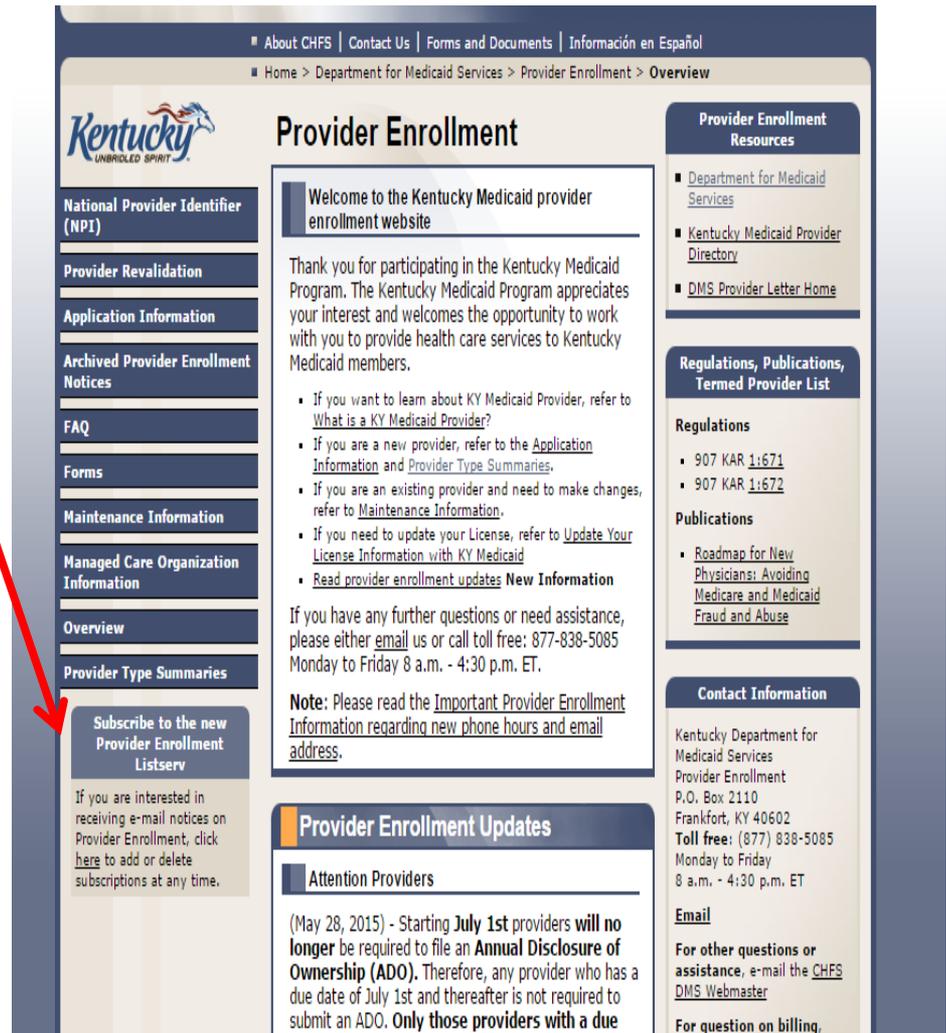
For more information, or to subscribe to the listserv, please visit:

<http://www.chfs.ky.gov/dms/provEnr/>

## Contact Information:

Provider Licensing and Certification Branch:  
1-877-838-5085

[program.integrity@ky.gov](mailto:program.integrity@ky.gov)



The screenshot shows the Kentucky Medicaid Provider Enrollment website. The top navigation bar includes links for 'About CHFS', 'Contact Us', 'Forms and Documents', and 'Información en Español'. The main content area is titled 'Provider Enrollment' and features a welcome message, a list of helpful links (such as 'What is a KY Medicaid Provider?', 'Application Information', and 'Maintenance Information'), and a 'Provider Enrollment Updates' section. The left sidebar contains a menu of navigation options, including 'National Provider Identifier (NPI)', 'Provider Revalidation', 'Application Information', 'Archived Provider Enrollment Notices', 'FAQ', 'Forms', 'Maintenance Information', 'Managed Care Organization Information', 'Overview', 'Provider Type Summaries', and 'Subscribe to the new Provider Enrollment Listserv'. The right sidebar contains 'Provider Enrollment Resources', 'Regulations, Publications, Termed Provider List', and 'Contact Information'.