Mental Health Providers

New Provider Specialties

Effective with dates of service on and after January 1, 2011, a licensed master’s level psychologist (LMLP) and licensed clinical psychotherapist (LCP) will have new provider specialties. The new provider specialties are:

- 108: Licensed Master’s Level Psychologist
- 109: Licensed Clinical Psychotherapist

Requests for updates to Medicaid provider enrollment profiles or submission of new enrollment applications can begin October 1, 2010.

Currently enrolled LMLPs or LCPs

LMLPs currently enrolled with provider specialty 115 or LCPs enrolled with provider specialty 116 must update their Medicaid provider enrollment profiles to add the new specific provider specialties. This requires the following:

- Complete a new specialty page (attached).
- Complete a new Disclosure of Ownership and Control Interest Statement (attached).
- Return all documentation to the address below:
  KHPA Medical Plans
  Office of the Fiscal Agent
  Provider Enrollment
  P. O. Box 3571
  Topeka, KS 66601-3571

Note: Current Behavioral Sciences Regulatory Board (BSRB) licensing requirements still apply. This process must be completed for reimbursement of claims billed with dates of service on and after January 1, 2011.

New providers

To become a new provider under one of these specialties, a nonphysician enrollment application must be completed and returned. The application can be found on the Provider Enrollment Applications page of the KMAP public website. For questions concerning enrollment, contact Provider Enrollment at 785-274-5914.

Information about the KHPA Medical Plans as well as provider manuals and other publications are available at https://www.kmap-state-ks.us. If you have any questions, contact Customer Service at 1-800-933-6593 (in-state providers) or 785-274-5990 from 8:00 a.m. until 5:00 p.m., Monday through Friday.
SPECIALTY LISTING – Nonphysician Practitioner

27 – DENTIST
ATTACH A COPY OF CURRENT LICENSE (required).
   _____ 270 Endodontist
   _____ 271 General Dentistry Practitioner
   _____ 272 Oral Surgeon
   _____ 273 Orthodontist
   _____ 274 Pediatric Dentistry
   _____ 275 Periodontist

For dental providers only. Please indicate if you would like to enroll as a Title 19 provider and/or a HealthWave 21 provider.

   Title 19
   HealthWave 21

11 – MENTAL HEALTH PROFESSIONAL
Attach a copy of license from Kansas Behavioral Sciences Regulatory Board or equivalent for border cities (cities within 50 miles of the Kansas border).
   _____ 108 Licensed Master’s Level Psychologist – LMLP (effective 01/01/2011)
   _____ 109 Licensed Clinical Psychotherapist – LCP (effective 01/01/2011)
   _____ 115 Licensed Mental Health Professional – LMHP
         Licensed: master’s degree level social worker, marriage & family therapist, counselor
   _____ 116 Licensed Clinical Mental Health Professional – LCMHP
         Licensed clinical: Specialist social worker, marriage & family therapist, professional counselor

17 – THERAPIST
ATTACH A COPY OF CURRENT LICENSE (required).
   _____ 170 Physical Therapist
   _____ 171 Occupational Therapist (effective 10/01/2009)

18 – OPTOMETRIST
ATTACH A COPY OF CURRENT LICENSE (required).
   _____ 180 Optometrist

19 – OPTICIAN
NO LICENSE IS REQUIRED.
   _____ 190 Optician
   _____ 191 Ocularist

20 – AUDIOLOGIST
ATTACH A COPY OF CURRENT LICENSE (required).
   _____ 200 Audiologist

23 – NUTRITIONIST
ATTACH A COPY OF CURRENT LICENSE (required).
   _____ 230 Nutritionist

56 – WORK (Work Opportunities Reward Kansans)
BUSINESSES AND AGENCIES ARE ELIGIBLE TO ENROLL TO PROVIDE THESE SERVICES. INDIVIDUALS ARE NOT ELIGIBLE TO ENROLL TO PROVIDE THESE SERVICES BUT MUST BE EMPLOYED BY A BUSINESS OR AGENCY THAT IS ENROLLED.

   _____ 506 INDEPENDENT LIVING COUNSELOR (Code T1016)
         Businesses and agencies eligible to enroll include a community developmental disability organization (CDDO) or CDDO affiliate, a center for independent living (CIL), or home health agency (HHA). Employees providing the service must meet the training requirements for an independent living counselor.

   _____ 522 ASSESSMENT SERVICE (Code T1023)
         Businesses and agencies must be selected by the Kansas Health Policy Authority (KHPA) to provide this service. Contractor(s) or any agency connected with them cannot provide any other WORK services, including independent living counseling, personal services, assistive services, or fiscal management.

   _____ 526 ASSISTIVE SERVICES (Code S5165)
         Businesses and agencies must meet the standards set in K.A.R. 129-5-118 or be one of the following agencies: CDDO or CDDO affiliate, CIL, HHA or the designated WORK fiscal manager(s).

Rev. 08/10
KANSAS MEDICAL ASSISTANCE PROGRAM

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

All sections must be completed for an application to be considered. Please insert “NA” if the question is not applicable.

Identifying Information

a. Name of Applicant: ____________________________________________________
   
i. Name of Entity, if different: _____________________________________________________________________
   
ii. DBA: _______________________________________________________________________________________
   
iii. Provider Number: _____________________________________________________________________________
   
iv. NPI: _______________________________________________________________________________________
   
v. Vendor Number: ______________________________________________________________________________
   
vi. Telephone Number: __________________________________________________________________________
   
 vii. Street Address: ______________________________________________________________________________
   
 viii. City, County, State: _________________________________________________________________________
   
 ix. Zip Code: _________________________________________________________________________________

b. Type of Entity:
   
   _____ Sole Proprietorship
   
   _____ Partnership
   
   _____ Corporation
   
   _____ Unincorporated Associations
   
   _____ Other (Please Specify):

   c. Contact Information for audits, if different than above. Address should be the location of the records required to be kept under K.A.R. 30-5-59, P.O. Boxes and drop boxes are not an acceptable response.

   Name _____________________________________________________
   
   Phone Number _____________________________________________
   
   Address _________________________________________________

Ownership Information

   a. List all corporations, unincorporated associations, partnerships, or similar entities having 5% or more direct or indirect ownership, or control interest, in the applicant/provider or any partnership interest in the applicant/provider identified above. Please indicate whether any person(s) named is related to any other
person(s) named above or below as spouse, parent, child or sibling. The following information is required:

Name:
Social Security Number:
Tax Identification Number:
Date of Birth:
Home Address:
Relationship:

b. Is this application a result of an assumption of control or purchase of a pre-existing business to include a change in corporate or partnership status in this or any other state?

i. If yes, please list each and every pre-existing business and tax identification of that business: _____________________________________________________

c. Does the pre-existing business have any outstanding debt owed to either the State of Kansas or the Federal government?

If yes, is there a debt assumption agreement in place? If so, please provide a copy of the debt assumption agreement. Please note that any debt of the previous owners will automatically be assumed to pass on to the new owners, unless a different agreement is presented with this application.

If this application is for a Group, please complete the following questions.

a. Are there any individuals or organizations having a direct or indirect ownership or controlling interest of five percent or more in the group that have been convicted of a criminal offense related to the involvement of such individuals or organizations in any of the programs established by any federal or state funded program?

If yes, please explain:

b. Are there any directors, officers, agents, or managing employees of the group who have ever been convicted of a criminal offense related to their involvement in such programs as established by any federal or state funded program?

If yes, please explain:

c. Are there any individuals currently employed by the group in a managerial, accounting, auditing, or similar capacity who were employed by the group’s fiscal intermediary or carrier within the previous 12 months?

If yes, please explain:

d. Has there been a change in ownership or control within the last year?

If yes, please explain:
e. Has there been a change in administrator, Director of Nursing or Medical Director within the last year? 
If yes, please explain:

f. Do you anticipate any change of ownership or control within the year? 
If yes, please provide and approximate date:

g. Do you anticipate filing for bankruptcy within the year? 
If yes, please provide and approximate date:

h. Is the group operated by a management company, or leased in whole or part by another organization?

i. Is the group chain affiliated? 
If you answer yes to h or i, please provide information about the corporation below:

Name:  
Tax Identification Number:  
Address:

If you answered no to i, was the group ever chain affiliated? 
If yes, please provide the following information for the corporation:

Name:  
Tax Identification Number:  
Address:

j. Has your bed capacity been increased by 10 beds or by 10 or more percent, whichever is greater, within the last two years? 
If yes, provide information about the changes below:

Year of change 
Current number of beds  
Prior beds 

k. Is this organization a provider based facility? 

l. Does this organization file a consolidated cost report under another’s Medicaid Provider Number? 
If yes, please provider the other Medicaid provider number.

m. What is the name of the Parent Company (Medicaid Provider’s Name)
n. Have you or the group ever participated as a provider in the Kansas Medical Assistance Program or in another state’s Medicaid program?

If yes, please provide all relevant provider names and Tax IDs.

o. Have the managing or directing officers or employee(s) ever had a Medicaid provider number in this or any other state?

If yes, please provide all relevant provider names and Tax ID’s.

If this application is for an individual, please complete the following questions:

a. Have you ever been convicted of any healthcare – related crime?

b. Have you ever been convicted of a felony under Federal or State law?

c. Do you have any outstanding criminal fines?

d. Have you ever participated as a provider in the Kansas Medical Assistance Program or in another state’s Medicaid program?

If yes, please provide all relevant provider names and Tax ID’s.

e. Have the managing or directing officers or employee(s) ever had a Medicaid provider number in this or any other state?

If yes, please provide all relevant provider names and Tax ID’s.

For Both Group and Individual Applicants, Please Complete the Following:

a. Family Relationships

i. Has any family or household member of any person who has ownership or controlling interest in the group ever been convicted, assessed, or excluded from the Medicaid program or any other Federal program due to fraud, obstruction of an investigation, or a controlled substance violation?

If yes, provide information about the person(s) affiliated with the organization and their family or household member below:

Name:  
Affiliated to organization:  
Name of family or household member:  
Relationship:  

ii. Do you or any family member of the group, or any other family or household member of you or the group; have any outstanding overpayments with Medicaid or any other federal program?
If yes, provide information on the overpayment(s) below:

Name of program:
Name under which overpayment exists:
Provider number under which the overpayment exists:
Arrangements that have been made to fulfill that obligation(s):

Please submit copies of all documents pertaining to the arrangements including terms and conditions.

b. Exclusions/Sanction Information

If you have ever had any of the following adverse legal actions imposed by Medicaid or any other Federal agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed.

If you have had no adverse legal actions, check the “None of These” box.

Important: Attach copy of adverse legal action notification(s):

Non-Healthcare Related

- Criminal Conviction
- Administrative sanction
- Program Exclusion
- Suspension of payment
- Civil Monetary Penalty
- Assessment
- Program Debarment

Healthcare Related

- Criminal Conviction
- Administrative sanction
- Program Exclusion
- Suspension of payment
- Civil Monetary Penalty
- Assessment
- Program Debarment
- Criminal Fine
- Restitution Order
- Pending Civil Judgment
- Pending Criminal Judgment
- Judgment pending Under the False Claims Act

If you have had no adverse legal actions, check here:

- None of these
ANY DOCUMENTATION OR ANSWERS PROVIDED ON THIS APPLICATION, INCLUDING THE LACK OF DOCUMENTATION OR ANSWERS, MAY BE USED IN THE CONSIDERATION OF THIS APPLICATION FOR APPROVAL. THE STATE IS ONLY REQUIRED TO APPROVE APPLICANTS THAT IT CONSIDERS TO MEET THE FEDERAL, STATE AND AGENCY GUIDELINES FOR PROGRAM INTEGRITY AND PROVIDER ENROLLMENT.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY OF HEALTH AND HUMAN SERVICES AS APPROPRIATE.

Name of Application Preparer, if different than the Applicant ___________________________

Name of Authorized Representative (Typed) _________________________________________

Signature of Authorized Representative _____________________________________________

Title _________________________________________________________________________

Date _____________

If Executed Outside of Kansas

I declare under penalty of perjury under the laws of the state of Kansas that the foregoing is true and correct. Executed on ______ (date).

___________________________
(Signature)

If Executed in Kansas

I declare under penalty of perjury that the foregoing is true and correct. Executed on ______ (date).

___________________________
(Signature)