

Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

HCBS APPLICATION CHECKLIST

Below is a checklist for your convenience to help ensure that all forms are completed in their entirety. **If any of the following items are not complete, do not contain original signatures, or are not dated, or if required items are not returned, your entire application will be returned.**

Sign the application in BLUE ink. This helps minimize any confusion regarding original signatures. Copies of signed forms and/or stamped signatures are not acceptable.

_____ **Kansas Medical Assistance Program (KMAP) provider application**

If a question is not applicable, mark N/A in the corresponding field.
Original signature and date are required.

_____ **Waiver listings with specialties**

Mark the specialty(ies) you wish to enroll in.
Attach required documents including license as specified.

_____ **Affiliate agreement (if required)**

Contact your area Community Developmental Disability Organization (CDDO) to obtain an affiliate agreement.

_____ **HCBS Provider Certification Statement**

Original signature and date required.

_____ **HCBS Provider Agreement Addendum**

Original signature and date required.

_____ **Disclosure of Ownership and Control Interest Statement**

Name, phone number, and address must be filled in.
All questions or boxes must be completed or checked.
Original signature and date required.

_____ **KMAP Provider Agreement**

All four boxes on the first page must be completed.
Original signature and date must be on page 6 of 6.

Note: If the effective date requested is prior to the signature date of the provider agreement, a claim showing services were rendered on or before the requested effective date must be attached.

_____ **W-9**

A copy of the W-9 is required.

_____ **Application fee, if applicable**

Refer to General Bulletin 11043 attached to this application.



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From the office of the Fiscal Agent

Dear prospective provider:

Thank you for your interest in the Kansas Medical Assistance Program (KMAP).

The application materials listed below must be completed and returned to the fiscal agent so your enrollment can be processed. Submission of incomplete application materials will delay your enrollment.

- KMAP Application
- Specialty Listing
- The Ownership and Control Interest Disclosure Statement
- KMAP Provider Agreement
- A copy of your current license (if required)

In order to facilitate the assignment of a provider number, please complete and submit the application materials with ORIGINAL SIGNATURES. Please retain copies of your application materials for your records.

You will receive written notification upon approval or denial of your enrollment.

All claims must be received by the current fiscal agent within one year from the date of service. Claims not received in a timely manner (within one year from the date of service) will not be considered for reimbursement except for claims submitted to Medicare, claims determined to be payable by reason of appeal or court decision, or as a result of agency error.

Regulations regarding payment of services to out-of-state providers (more than 50 miles from the Kansas border) allow payment consideration for out-of-state services provided to KMAP beneficiaries if one of the following situations exist:

- An out-of-state provider may be reimbursed for covered services required on an emergency basis.
- An emergency is defined as those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
- In these situations, please contact the KMAP Prior Authorization department to receive authorization prior to services being rendered. Failure to contact the Prior Authorization department may result in denial of your claim.
- An out-of-state provider may be reimbursed for nonemergency services if the Prior Authorization department, on behalf of the Kansas Department of Health and Environment, Division of Health Care Finance, determines that the services are medically necessary. Failure to meet either of the above situations may result in denial of your claim.

If either situation presently exists or may exist, then please complete the enclosed application forms and be sure that all information requested is provided.

If you have questions concerning enrollment, please contact Provider Enrollment at P.O. Box 3571, Topeka, Kansas 66601 or by telephone at 785- 274-5914, between 8:00 a.m. and 4:30 p.m., Monday through Friday. If you have any questions regarding prior authorization, please call 1-800-285-4978.

Sincerely,

KMAP Provider Enrollment



November 2011

Provider Bulletin Number 11152

General Providers

Application Fee Update

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications and all applications submitted as part of the provider revalidation. The following providers are exempt from the application fee:

- Individual providers or nonphysician practitioners
- Providers who enrolled with Medicare or another state Medicaid plan after March 25, 2011
- Providers who paid the application fee to either Medicare or another state Medicaid plan

The application fee for 2012 will be \$523.00. Payment must be made in the form of a bank-certified check or money order made out to the State of Kansas – Medicaid. This amount will go into effect for any application received on and after January 1, 2012.

Note: In order to waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required and must be dated after March 25, 2011. For Medicare providers, a copy of your most recent Medicare explanation of benefits (EOB) is also acceptable proof of active enrollment. Proof of payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee.

If an application is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the entire application will be returned to the provider requesting proper payment.

Information about the Kansas Medical Assistance Program (KMAP) as well as provider manuals and other publications is available at <https://www.kmap-state-ks.us>.

If you have any questions, please 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.



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Choose One: New Enrollment Revalidation

Kansas Medical Assistance Program (KMAP) PROVIDER APPLICATION

This application must be completed in its entirety. Do not leave any questions blank. If a question is not applicable, indicate so with an N/A in the appropriate field. Incomplete applications will result in a delay in the processing of your application.

Section A

BUSINESS NAME OR PROVIDER NAME: _____

OR PROVIDER: _____
First Middle Last

PROVIDER'S SOCIAL SECURITY NUMBER: _____

PROVIDER'S TAX IDENTIFICATION NUMBER: _____

PROVIDER'S LICENSE/CERTIFICATION NUMBER: _____

LICENSE/CERTIFICATION EFFECTIVE AND EXPIRATION DATES: FROM _____ TO _____

PROVIDER'S NPI: _____ TAXONOMY CODE: _____
A copy of the letter or e-mail received from NPPES assigning the NPI is required.

DEA NUMBER: _____

GROUP NUMBER: _____
If a group number is not indicated, the provider will not be listed as a member of the group.

GROUP NPI: _____ GROUP TAXONOMY CODE: _____

WAS THE PREVIOUS PROVIDER ENROLLED IN THE KANSAS MEDICAL ASSISTANCE PROGRAM?

YES _____ NO _____

PREVIOUS KMAP PROVIDER NAME AND NUMBER:

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES:



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TYPE OF PRACTICE ORGANIZATION:

INDIVIDUAL PRACTICE PARTNERSHIP CORPORATION
 CHARITABLE PRIVATELY OWNED LLC
 HOSPITAL-BASED PHYSICIAN OTHER MUNICIPAL OR STATE-OWNED

PROVIDER'S PHYSICAL LOCATION (This is the practice or physical site location.)

ADDRESS _____
 CITY _____ STATE _____ COUNTY _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S MAIL TO ADDRESS (This is the address to which correspondence will be mailed.)

ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S PAY TO ADDRESS (This is the address to which payments will be mailed.)

PAYEE NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S HOME OFFICE ADDRESS (This is the address of business home office.)

ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____



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SECTION B

For groups or professional associations only.

NAME OF GROUP: _____

EXISTING GROUP? YES _____ NO _____

EXISTING GROUP KMAP PROVIDER NUMBER: _____ NPI: _____
A copy of the letter or e-mail received from NPPES assigning the NPI is required.

GROUP SPECIALTY: _____ TAXONOMY CODE: _____

GROUP'S TAX IDENTIFICATION NUMBER: _____

If new group, effective date KMAP beneficiaries will be seen: _____

If a group, please list all members in the group:

<u>NAME</u>	<u>CREDENTIALS</u>	<u>KMAP PROVIDER ID</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

If additional space is needed, please use a separate sheet.

SECTION C

PROVIDER SPECIALTY/PRACTICE DATA

USING THE SPECIALTY LISTING ATTACHED, PLEASE INDICATE THE KMAP SPECIALTY BEING REQUESTED.

PRIMARY: _____ SECONDARY: _____

KANSAS SCHOOL DISTRICT (for physical location): _____



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SECTION D

Are you a proprietor, investor, partner, superintendent, executive officer, business member, or consultant of any clinical lab, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? YES: _____ NO: _____

If yes, please provide the following information:

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

NAME OF ORGANIZATION: _____

TAX IDENTIFICATION NUMBER: _____ **TELEPHONE NUMBER:** _____

STREET ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____
(nine-digit)

TYPE OF ORGANIZATION: _____ **SIZE OF ORGANIZATION:** _____

PERCENT OF BUSINESS OWNED/INVESTED BY PRACTITIONERS OR HOSPITALS: _____

PERCENT OF BUSINESS OWNED/INVESTED BY APPLICANT: _____

NATURE OF BUSINESS INTEREST: _____
(for example, owner, partner, investor)

SECTION E

LABORATORY INFORMATION

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires all providers at all locations performing laboratory testing, including in-office laboratories, to be registered with the CLIA program.

CLIA NUMBER: _____ **EFFECTIVE DATE:** _____ **CANCELLATION DATE:** _____



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SECTION F

Kansas Medical Assistance Program Provider Binder

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Kansas Medical Assistance Programs.

I understand that should I be enrolled as a provider of services under the Kansas Medical Assistance Programs, that it is my responsibility to notify the Kansas Medical Assistance Programs' fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.
Provider Signature:

Authorized Signature: _____

By: _____

Title: _____

Date: _____

CONTACT PERSON FOR QUESTIONS PERTAINING TO THIS APPLICATION, NAME AND PHONE NUMBER:

Please mail completed application to:

**Provider Enrollment Department
P.O. Box 3571
Topeka, KS 66601-3571**

Kansas Medical Assistance Program

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SPECIALTY LISTING – AUTISM (AU) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- _____ **550 AUTISM SPECIALIST***(effective 01/01/2008)*
Master's degree, preferably in human services or education, and documentation of 2,000 hours of experience working with a child with autism spectrum disorder (ASD) OR a board-certified behavior analyst (BCBA) and documentation of 2,000 hours of experience working with a child with ASD; successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid Registry, and Motor Vehicle screens. * Exception: A BCBA can request the program manager to waive 1,000 hours of the required experience if there is documentation indicating the hours of supervised experience working with a child with ASD. Does require a national provider identifier (NPI).
- _____ **551 INTENSIVE INDIVIDUAL SUPPORTS-AU***(effective 01/01/2008)*
Bachelor's degree, preferably in human services or education, and documentation of 1,000 hours experience working with a child with ASD OR 60 college credit hours and documentation of 1,000 hours experience working with a child with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does require an NPI.
- _____ **552 RESPITE CARE-AU***(effective 01/01/2008)*
High school diploma or equivalent; 18 years of age or older; must reside outside of child's home. Respite care cannot be provided by a parent of the child. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does not require an NPI.
- _____ **553 PARENT SUPPORT-AU***(effective 01/01/2008)*
High school diploma or equivalent; 21 years of age or older; must have three years of direct care experience with a child with ASD or be the parent of a child three years of age or older with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does require an NPI.
- _____ **554 FAMILY ADJUSTMENT COUNSELING-AU***(effective 01/01/2008)*
Must hold a current license to practice as a licensed mental health professional (LMHP) by the State of Kansas Behavioral Sciences Regulatory Board. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must maintain an ongoing collaborative relationship with the autism specialist beginning at the time of referral. Does require an NPI.
- _____ **173 INTERPERSONAL COMMUNICATION THERAPY***(effective 01/01/2011)*
Must hold a current license to practice as a licensed speech/language pathologist with a certificate of clinical competence from the American Speech and Hearing Association, and have documentation of 1,000 hours experience working with a child with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Does require an NPI.

To meet documentation requirements, an applicant must include in his or her enrollment packet all of the items which are relevant to the identified service they are seeking to provide from the list below:

- Current license
- Certification for BCBA
- Certificate of clinical competence from the American Speech and Hearing Association
- Transcripts (if a transcript does not indicate autism specifically, must attach syllabi)
- Supervisor's statement and/or documentation on official letterhead verifying the hourly requirement
- Copy of master's degree, bachelor's degree, high school diploma or equivalent
- Resume
- Copy of records indicating KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens successfully passed

All documentation will be reviewed by the autism waiver program manager.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

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SPECIALTY LISTING – FRAIL ELDERLY (FE) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

410 ADULT DAY CARE

Kansas Department of Aging (KDOA) must license providers. Licensed entities for this service include freestanding adult day care facilities, nursing facilities, assisted living facilities, residential health care facilities, and home plus facilities.

441 ASSISTIVE TECHNOLOGY

Any business, agency, or company that furnishes assistive technology items or services is eligible to enroll. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, a letter from the county or city must be provided stating licensure or certification is not required.

510 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL I

Service A includes: shopping, house cleaning, meal preparation, and laundry services only.

Service B includes: supervision of medication cueing and reminding, bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, and accompaniment to obtain necessary medical services.

For Service A only — Qualified providers include nonmedical resident care facilities licensed by the Kansas Department of Social and Rehabilitation Services (SRS). Entities not licensed by SRS, KDOA, or the Kansas Department of Health and Environment (KDHE) must be set up with Articles of Incorporation or Articles of Organization as a business filed with the secretary of state in the State of Kansas. If the corporation or limited liability company is in a jurisdiction outside the State of Kansas, written proof must be provided showing authorization to do business in the State of Kansas. Written proof of liability insurance or a surety bond must also be provided.

For Services A and B — Qualified providers include county health departments, boarding care homes licensed by KDOA, and the following entities licensed by KDHE: state-licensed home health agencies (HHAs) and Medicare-certified HHAs.

511 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL II

Service C includes: physical assistance or total support with bathing, grooming, dressing, toileting, transferring, walking/mobility, and eating, and accompaniment to obtain necessary medical services.

Service D includes: health maintenance activities (limitations apply).

For Services C and/or D — Qualified providers include county health departments and the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs.

511 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL III *(effective 11/1/11)*

Service includes: supervision, physical assistance, or total support with shopping, house cleaning, meal preparation, laundry, bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompaniment to obtain necessary medical services, and health maintenance activities (limitations apply).

Qualified providers include the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities.

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518 COMPREHENSIVE SUPPORT - PROVIDER-DIRECTED (effective 08/1/2008)

Note: Previously Senior Companion Service from 08/01/2008 through 06/30/2009.

Qualified providers include county health departments and the following entities licensed by KDHE: state-licensed HHAs, Medicare-certified HHAs, and centers for independent living (CILs) recognized by SRS. Entities not licensed by KDHE must be set up with Articles of Incorporation or Articles of Organization as a business filed with the secretary of state in the State of Kansas. If the corporation or Limited Liability Company is in a jurisdiction outside the State of Kansas, it shall provide written proof of authorization to do business in the State of Kansas. Written proof of liability insurance or surety bond must also be provided.

530 FINANCIAL MANAGEMENT SERVICES (FMS) (effective 11/1/2011)

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS FE services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment in FMS also requires enrollment in each of the following HCBS FE services that are allowable for self-direction:

- ___ **511 ATTENDANT CARE – SELF-DIRECTED**
- ___ **518 COMPREHENSIVE SUPPORT – SELF-DIRECTED**
- ___ **513 SLEEP CYCLE SUPPORT**

531 HOME TELEHEALTH – INSTALLATION/TRAINING (effective 10/1/11)

This service can be provided by HHAs or county health departments with system equipment capable of monitoring beneficiary vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. The equipment must also be capable of asking the beneficiary questions that are tailored to the beneficiary's diagnosis. The provider and equipment must have needed language options – e.g. English, Spanish, Russian, and Vietnamese.

532 HOME TELEHEALTH (effective 10/1/11)

This service can be provided by HHAs or county health departments with system equipment capable of monitoring beneficiary vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. The equipment must also be capable of asking the beneficiary questions that are tailored to the beneficiary's diagnosis. The provider and equipment must have needed language options – e.g. English, Spanish, Russian, and Vietnamese. Does require a national provider identifier (NPI).

509 MEDICATION REMINDER (effective 5/16/2005)

Any company providing a medication reminder service is eligible to enroll. Adult care homes are excluded from enrolling to provide this service.

515 NURSING EVALUATION VISIT

Qualified providers include county health departments, self-employed registered nurses licensed in Kansas, the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs, and the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities. Does require a NPI.

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_____ **252 PERSONAL EMERGENCY RESPONSE — INSTALLATION**

Any company providing personal emergency response systems is eligible to enroll.

_____ **253 PERSONAL EMERGENCY RESPONSE — RENTAL**

Any company providing personal emergency response systems is eligible to enroll.

_____ **514 WELLNESS MONITORING**

Qualified providers include county health departments, self-employed registered nurses licensed in Kansas, the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs, and the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities. Does require a NPI.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

Rev. 12/11

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SPECIALTY LISTING – MR/DD WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- ___ **268 MEDICAL ALERT RENTAL** Community developmental disability organization (CDDO) certificate or affiliate agreement. Does not require a national provider identifier (NPI).
- ___ **362 FAMILY/INDIVIDUAL SUPPORT** (*effective 08/01/1999 and ending 08/31/2009*) CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **364 RESIDENTIAL SUPPORT-MRDD** (*effective 07/01/1998*) For children – must be affiliated with the CDDO for area where operating and be licensed by the Kansas Department of Health and Environment (KDHE) as a child placing agency (K.A.R. 28-4-171). For adults – CDDO or affiliate agreement and be licensed by the Kansas Department of Social and Rehabilitation Services (SRS) to provide residential services. No more than eight adults in one home. Does not require an NPI.
- ___ **365 SUPPORTIVE HOME CARE-MRDD** CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **368 SLEEP CYCLE SUPPORT-MRDD** CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **369 SUPPORTED EMPLOYMENT SERVICES-MRDD** (*effective 03/15/2008*) CDDO certificate or affiliate agreement and licensed by SRS to provide this service. Does not require an NPI.
- ___ **370 PERSONAL ASSISTANT SERVICES-MRDD** (*effective 03/15/2008*) CDDO certificate or affiliate agreement. Does require an NPI.
- ___ **440 ASSISTIVE SERVICES** (*effective 03/15/2008*) CDDO or affiliate agreement. Does not require an NPI.
- ___ **512 RESPIRE CARE (Temporary)** (*ended 02/01/2010*) CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **512 RESPIRE CARE (Overnight)** For children – CDDO or affiliate agreement. Does not require an NPI.
- ___ **517 WELLNESS MONITORING** CDDO certificate or affiliate agreement along with a home health agency (HHA) license issued by KDHE or a registered nurse (RN) license issued by the Kansas State Board of Nursing. Does require an NPI.
- ___ **520 DAY SUPPORT-MRDD** (*effective 07/01/1998*) CDDO certificate or affiliate agreement and licensed by SRS to provide this service. Does not require an NPI.
- ___ **521 SPECIALIZED MEDICAL CARE – RN** (*effective 09/01/2009*) CDDO certificate or affiliate agreement. Must be licensed as an RN. Does require an NPI. If not associated with a HHA, must obtain written permission from the Mental Retardation Developmental Disabilities (MRDD) program manager.
- ___ **523 SPECIALIZED MEDICAL CARE – LPN** (*effective 09/01/2009*) CDDO certificate or affiliate agreement. Must be licensed as a licensed practical nurse (LPN). Does require an NPI. If not associated with a HHA, must obtain written permission from the MRDD program manager.
- ___ **530 FINANCIAL MANAGEMENT SERVICES (FMS)** (*effective 11/1/2011*) CDDO certificate or affiliate agreement. FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS MRDD services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment to provide FMS also requires enrollment to provide at least one of the services that can be self-directed on the HCBS MRDD waiver. Those services are Personal Assistant Services, Sleep Cycle Support, Overnight Respite, Specialized Medical Care RN, and Specialized Medical Care LPN. FMS providers will need to execute agreements with individual providers of these services.

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SPECIALTY LISTING - PHYSICAL DISABILITY (PD) WAIVER

Businesses/companies only

(Individuals may contract with any qualified provider agency or independent living counseling agency.)

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

_____ **500 ASSISTIVE SERVICES**

Contractors or companies chosen to provide adaptations to housing structures must be licensed by the county or city in which they work and all work must be performed to existing building codes. Durable medical equipment suppliers must be enrolled with Medicaid, meeting standards set in K.A.R. 30-5-108. Does not require a national provider identifier (NPI).

_____ **535 HOME-DELIVERED MEALS (HDM) (Effective 11/1/2011)**

Providers must have on staff or contract with a certified dietician to ensure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act. Does not require a NPI.

_____ **509 MEDICATION REMINDER SERVICES (Effective 11/1/2011)**

Any provider who offers a scheduled reminder to a beneficiary indicating when the beneficiary is to take medications. The reminder may be a phone call, automated recording, automated alarm, or dispenser with an alarm, depending on the provider's system. The provider also offers installation of the medication dispenser. Does not require a NPI.

_____ **367 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

Any company providing personal emergency response systems is eligible to enroll. Does not require a NPI.

_____ **367 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) INSTALLATION**

Any company providing personal emergency response systems with the ability to install the system is eligible to enroll. Does not require a NPI.

_____ **367 PERSONAL SERVICES (Choose Agency-Directed and/or Self-Directed) (Effective 11/1/2011)**

An adult beneficiary's spouse or a minor beneficiary's parents shall not be paid to provide this service unless granted an exception as outlined in K.A.R. 30-5-307. Does not require a NPI.

S5126 PERSONAL SERVICES – AGENCY-DIRECTED

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. Agencies providing Personal Services must be licensed home health agencies and enrolled with the State's fiscal agent.

S5126 U6 PERSONAL SERVICES – SELF-DIRECTED

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. Individual, nonenrolled providers of Personal Services must enter into an agreement with an enrolled provider of Financial Management Services (FMS).

_____ **367 SLEEP CYCLE SUPPORT (SCS)**

Support staff must be at least 18 years of age. Agencies providing Sleep Cycle Support must enroll with the State's fiscal agent. Individual, nonenrolled providers must enter into an agreement with an enrolled provider of FMS. Does not require a NPI.

_____ **530 FINANCIAL MANAGEMENT SERVICES (FMS) (Effective 11/1/2011)**

FMS provides administrative tasks and information & assistance tasks for those beneficiaries choosing to self-direct HCBS PD services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must meet all of the requirements as specified in the *HCBS FMS Provider Manual*. Enrollment to provide FMS also requires enrollment to provide Personal Services – Self-Directed and Sleep Cycle Support, the HCBS PD services that provide the option to self-direct. FMS providers will need to execute agreements with individual providers of these services.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SPECIALTY LISTING – TARGETED CASE MANAGEMENT

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

Type 21

237 TARGETED CASE MANAGEMENT — FRAIL ELDERLY (FE)

A provider of Targeted Case Management (TCM) for the Frail Elderly (FE) services cannot also provide Home and Community Based (HCBS) FE waiver direct services including, but not limited to, self-direct/payroll agent services since this would create a conflict of interest. A targeted case manager employed by or under contract with a case management entity (CME) cannot also be employed by or under contract with any entity which creates a conflict of interest by providing HCBS-FE waiver services.

To meet documentation requirements, applicants must include copies of the following items in their enrollment packet:

- Current driver's license
- Resumé
- Master's degree, bachelor's degree, or high school diploma or equivalent
- Transcripts from four-year accredited college or university, if applicable
- Certificates of completion for TCM-FE on-line training and uniform assessment instrument (UAI) training
- Evidence of clear background checks from the Kansas Bureau of Investigation (KBI), Kansas Adult Protective Services (APS), and Motor Vehicle screen, each dated within 30 days of the date of application
- Licensed nurses must provide verification of no disciplinary action from the Kansas Board of Nursing
- Licensed social workers must provide verification of no disciplinary action from the Kansas Behavioral Sciences Regulatory Board
- Written proof of professional liability insurance with minimum coverage in an amount not less than \$200,000 per occurrence and \$600,000 annual aggregate
- Evidence of a national provider identifier (NPI)
- If applicable, current Kansas registered professional nurse license
- If applicable, verification of Articles of Incorporation or Articles of Organization as a business filed with the Kansas Secretary of State or, if the corporation or limited liability company is in a jurisdiction outside the state of Kansas, applicant shall provide written proof that it is authorized to do business in the state of Kansas
- If applicable, community mental health center license, issued in accordance with K.A.R. 30-60-1
- If Area Agency on Aging (AAA), verification from the secretary of the Kansas Department on Aging that the applicant meets the regulatory requirements for AAA designation as defined by K.A.R. 26-1-1

Targeted case managers for FE must meet the following qualifications:

Senior Case Manager

- An individual with a four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, or family studies, and at least one year experience in the geriatric services field; or
- A registered professional nurse licensed to practice in the state of Kansas with at least one year experience in the geriatric services field

Junior I Case Manager

- An individual with a high school or general education diploma and four years work experience in the human services field with an emphasis in aging services; or
- An individual with a combination of four years work experience in the human services field and post-secondary education, with one year of work experience substituting for one year of education

Note: A senior case manager must supervise a junior I case manager.

Junior II Case Manager

- An individual with a high school or general education diploma and one year work experience

Note: A senior case manager must supervise a junior II case manager.

Note: Individuals providing TCM services through an AAA as of April 1, 2008, are deemed as meeting education and experience requirements.

Continued on next page

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237 TARGETED CASE MANAGEMENT — PHYSICALLY DISABLED (PD)

- Must have successfully completed the independent living counseling examination
- Must have at least six months personal experience with a disability as recognized by the Rehabilitation Act of 1973 (as amended) or have at least one year professional experience providing direct services to persons with a variety of disabilities
- Must have annual independent living philosophy training consisting of 12 hours of standardized training in history and philosophy of the National Independent Living Movement
- Must participate in all state-mandated HCBS-PD or independent living counseling training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program
- Must be a KMAP-enrolled provider of independent living counseling (TCM-PD)
- Does require an NPI

237 TARGETED CASE MANAGEMENT — TRAUMATIC BRAIN INJURY (TBI)

- Have at least six months experience with a disability as recognized by the Rehabilitation Act of 1973 or at least one year professional experience providing direct services, including case management, to a person or persons with a disability
- At least 12 hours of standardized training, annually, in the history and philosophy of the National Independent Living Movement
- Completion of a standard practicum to include observation of an assessment or assessments conducted by at least one qualified targeted case manager, and development of at least four assessments with monitoring and feedback provided by at least one qualified targeted case manager
- Completion of 40 hours of training regarding traumatic brain injury
- Annual demonstration of proficiency about the services, policies, rules, and procedures of the HCBS-TBI waiver program

Note: This is an agency responsibility and should be recorded in the TBI targeted case manager's personnel file.

- Does require an NPI

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

TARGETED CASE MANAGEMENT – MR/DD is located on the facility application.

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Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SPECIALTY LISTING – TECHNOLOGY ASSISTED (TA) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

___ **555 INDEPENDENT CASE MANAGEMENT-TA** (effective 08/01/2008)

Advanced registered nurse practitioner (ARNP) or registered nurse (RN) with bachelor's degree and two-year clinical experience in the nursing field. Hold a current license to practice in the capacity of a nurse in the State of Kansas. Must include a copy of your license, degree, and resume. Does require a national provider identifier (NPI).

___ **556 SPECIALIZED MEDICAL CARE/MEDICAL RESPITE-TA** (effective 08/01/2008)

Home health agency (HHA): Provider must be a RN or licensed practical nurse (LPN) trained with the medical skills necessary to care for and meet the medical needs of technology assisted (TA) beneficiaries. Must include a copy of your HHA license. Does not require a NPI. *A home health application will need to be filled out as well.*

___ **557 LONG-TERM COMMUNITY CARE ATTENDANT (AGENCY-DIRECTED)-TA** (effective 08/01/2008)

HHA: Medical service technician (MST), must be 18 years of age or older with a high school diploma or equivalent; must meet HHA's qualifications; must reside outside of beneficiary's home; must complete training and pass certification as regulated under K.A.Rs 28-39-165 or 28-51-100 by the State of Kansas licensing agency. Must include a copy of HHA license. Does not require a NPI. *A home health application will need to be filled out as well.*

___ **558 LONG-TERM COMMUNITY CARE ATTENDANT (SELF-DIRECTED)-TA** (effective 08/01/2008)

Must meet skill training delegated by parent and qualified medical provider; must reside outside of beneficiary's home. Providers must work under the direction of parent or legal guardian with the authority to direct services. Does not require a NPI.

___ **559 HOME MODIFICATION-TA** (effective 08/01/2008)

Any individual or business licensed or certified as a contractor to provide home modifications, provide adaptation services to existing structures, or assistive technology equipment to assist TA beneficiaries with their home environments. All services provided must meet the local city, county, and state building codes. An exception of certification or licensure requirement may be granted with a letter from the city or county of beneficiary's residence declaring certification or licensure is not required. Must include copy of license or certification. Does not require a NPI.

___ **560 HEALTH MAINTENANCE MONITORING (TA)** (effective 07/01/2011)

Local county health departments or HHAs licensed by KDHE: Provider must be a RN or LPN trained with the medical skills necessary to evaluate and monitor current and ongoing healthcare needs of TA beneficiaries. A LPN or RN performing this service under a KDHE-licensed HHA must comply with its licensing requirements. Must include a copy of your HHA license. Does require a NPI. *A home health application will need to be filled out as well.*

___ **561 INTERMITTENT INTENSIVE MEDICAL CARE (TA)** (effective 07/01/2011)

Local county health departments or HHAs licensed by KDHE: Provider must be a RN trained with the medical skills necessary to care for and meet the medical needs of TA beneficiaries as identified under the "Hydration/Specialty Care" elements of the MATLOC assessment. Must include a copy of your HHA license. Does require a NPI. *A home health application will need to be filled out as well.*

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From the office of the Fiscal Agent

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____ **530 FINANCIAL MANAGEMENT SERVICES (FMS)** (effective 11/1/2011)

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS TA services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Providers of FMS must also select specialty type 558 in order to manage self-directed attendant services.

Providers of Specialized Medical Care, Medical Respite, and Long-Term Community Care Attendant (agency-directed) must be employed under a HHA and meet the licensing standards as regulated by the Kansas State Board of Nursing (KSBN) and/or the Kansas Department of Health and Environment (KDHE) as specified in K.S.A 65-5101 through K.S.A. 65-5117.

Providers of all services must provide appropriate certification and licensure, if applicable, and must maintain a clear background as documented through the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), KSBN, and Department of Motor Vehicles (DMV).

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

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SPECIALTY LISTING – TRAUMATIC BRAIN INJURY (TBI) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- ___ **503 ASSISTIVE SERVICES (Contractors or Durable Medical Equipment)**
Contractors must be licensed according to local and county codes in which they work. Durable medical equipment suppliers must be enrolled with Medicaid, meeting standards set in KAR 30-5-108.
- ___ **177 BEHAVIOR THERAPY**
Licensed by the Kansas Behavioral Sciences Regulatory Board and master's degree in a behavioral science field (such as psychology or social work) or Special Education. Forty hours of training or at least one year of experience in working with individuals who have sustained a traumatic brain injury (TBI).
- ___ **178 COGNITIVE THERAPY**
Licensed by the Kansas Behavioral Sciences Regulatory Board and master's degree in a behavioral science field (such as psychology or social work) or Special Education. Forty hours of training or at least one year of experience in working with individuals who have sustained a TBI.
- ___ **536 HOME-DELIVERED MEALS** (*Effective 11/1/2011*)
Providers of this service must have on staff or contract with a certified dietician to ensure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act.
- ___ **509 MEDICATION REMINDER SERVICES** (*Effective 11/1/2011*)
Any company providing medication reminder services per industry standards is eligible to enroll. Services include a scheduled reminder (such as a phone call, automated recording, or automated alarm), medication dispenser with an alarm, and medication dispenser installation.
- ___ **171 OCCUPATIONAL THERAPY**
Licensed by the Kansas Board of Healing Arts. Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.
- ___ **170 PHYSICAL THERAPY**
Licensed by the Kansas Board of Healing Arts. Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.
- ___ **268 PERSONAL EMERGENCY RESPONSE SYSTEMS**
Any company providing personal emergency response systems.
- ___ **268 PERSONAL EMERGENCY RESPONSE SYSTEM INSTALLATION**
Any company providing personal emergency response systems with the ability to install the system.

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_____ **363 PERSONAL SERVICES (choose Agency-Directed and/or Self-Directed)**

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. An adult beneficiary's spouse or a minor beneficiary's parents must not be paid to provide this service unless granted an exception as outlined in K.A.R. 30-5-307.

PERSONAL SERVICES – AGENCY-DIRECTED

Agencies providing Personal Services must be licensed home health agencies (HHAs) and enroll with the State's fiscal agent.

PERSONAL SERVICES – SELF-DIRECTED

Individual, nonenrolled providers of Personal Services must enter into an agreement with an enrolled provider of Financial Management Services (FMS).

_____ **366 SLEEP CYCLE SUPPORT**

Support staff must be at least 18 years of age. Agencies providing Sleep Cycle Support must enroll with the State's fiscal agent. Individual, nonenrolled providers must enter into an agreement with an enrolled provider of FMS.

_____ **173 SPEECH/LANGUAGE THERAPY**

Licensed by Kansas Department of Health and Environment (KDHE). Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.

_____ **540 TRANSITIONAL LIVING SKILLS**

Must be a center for independent living (CIL) or HHA. Individuals employed by the agency must have at least 28 hours of training in TBI, complete a mandatory curriculum, and score 80% or better on the corresponding test.

_____ **530 FINANCIAL MANAGEMENT SERVICES (FMS) (Effective 11/1/2011)**

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS TBI services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment to provide FMS also requires enrollment to provide Personal Services –Self-Directed and Sleep Cycle Support, the HCBS TBI services that provide the option to self-direct. FMS providers will need to execute agreements with individual providers of these services.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____



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Kansas Medical Assistance Program HCBS Provider Certification Statement (06/08)

As a KMAP HCBS provider, I agree to adhere to the standard of quality of service which is implied by my enrollment as a provider of these services.

I will be available for provision of services to eligible KMAP beneficiaries as prescribed in the individual beneficiary's plan of care.

I will agree to refuse no referrals for services, except under the following conditions:

- If the beneficiary, the beneficiary's family, or both substantially interferes with the provider's ability to deliver services, including refusing service and interfering with the completion of work
- If a possibility exists of the beneficiary physically harming the provider or where violence has been previously noted
- If the beneficiary or a member of the beneficiary's family makes sexual advances, demonstrates sexually inappropriate behavior, uses sexually inappropriate language in the presence of the provider or any combination of such actions

If services are to be terminated by the provider, written notice of termination shall be given to the beneficiary or the beneficiary's family, except in instances of death or institutionalization. The notice shall be served by delivering a copy of the notice to the beneficiary and the case manager or by mailing a copy of the notice to the beneficiary at the beneficiary's last known address. Notice shall be served at least 30 calendar days prior to the effective date of the termination, except in cases of violent or sexually inappropriate behavior. The notice shall include the reasons for and the effective date of the termination.

Signature of Provider:

Agreement to these provisions must be signed by the individual or by an officer of the business to be receiving payments for approved services.

Agreed by: _____

Date: _____

Kansas Medical Assistance Program

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From the office of the Fiscal Agent

HCBS Provider Agreement Addendum – Expected Service Outcomes

Agencies providing Targeted Case Management (TCM) for Frail Elderly (FE):

1. Initial assessment of beneficiary needs shall occur within six working days of the request for services.
2. Each beneficiary obtaining services will be assigned a targeted case manager to coordinate the plan of care in a manner consistent throughout all service providers.
3. Completion of the plan of care and implementation of service provision shall occur within seven working days of the functional determination by the targeted case manager and the financial determination by Kansas Department for Aging and Disability Services (KDADS).
4. There shall be evidence of involvement by the beneficiary or beneficiary's representative in the development of the plan of care.
5. Ongoing evaluation and monitoring shall occur on a regular basis to ensure services are being provided according to the plan of care.
6. TCM services are provided in an efficient manner.
7. Targeted case managers provide quality services to the FE beneficiaries.
8. Documentation accurately reflects beneficiary health status, service provision, choice of providers, and coordination in accordance with the plan of care.
9. Documentation must adhere to state and federal rules, regulations, and requirements.
10. The number of service units reimbursed per beneficiary shall not exceed 800 units per year for TCM.
11. Targeted case managers receive appropriate notification of financial KMAP eligibility from KDADS and/or receive appropriate authorization of the plan of care prior to sending the notice of action.
12. At least 95% of beneficiaries receiving services shall report overall satisfaction with quality, access, and adequacy of services, to be identified by the State through a yearly beneficiary survey process.

Individuals or agencies providing any HCBS service:

1. Services are provided according to the plan of care, in a quality manner, and as authorized on the notice of action.
2. Services are coordinated and provided in a cost-effective manner.
3. Beneficiary's independence and health are maintained in a safe and dignified manner.
4. Beneficiary's concerns, needs, and/or changes in health status are communicated to the case manager within 48 hours, including any ongoing reporting as required by KMAP.
5. Any failure or inability to provide services as scheduled in accordance with the plan of care is reported immediately to the targeted case manager.
6. At least 95% of beneficiaries receiving services through the home health agency must report overall satisfaction with access, quality, and adequacy of services, to be identified by the State through a yearly beneficiary survey process.

Signature

Date

Kansas Medical Assistance Program

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From the office of the Fiscal Agent

HCBS Provider Agreement Addendum – Expected Service Outcomes

Agencies Providing Targeted Case Management (TCM) for Physically Disabled (PD):

1. Initial assessment of beneficiary needs will occur within five working days of the request for services.
2. Each beneficiary obtaining services will be assigned a case manager to coordinate the plan of care in a manner consistent throughout all service providers.
3. Completion of the plan of care and implementation of service provision will occur within 30 days from the date of offer of services or upon dismissal from institution or hospital. There will be evidence of involvement with the beneficiary or caregiver in the development of the plan of care.
4. Ongoing evaluation and monitoring will occur on a regular basis to ensure services are being provided according to the plan of care.
5. There will be a continual decrease in the number of unmet service needs experienced by the beneficiary through development of external resources in a cost-effective manner.
6. Documentation will accurately reflect beneficiary health status, service provision, choice of providers and coordination in accordance with the plan of care. Documentation will also adhere to state and federal rules, regulations and requirements.
7. The number of service units reimbursed per beneficiary will not exceed 120 hours (480 units) per year for TCM-PD.
8. At least 95 percent of beneficiaries receiving services will report overall satisfaction with quality, access, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Individuals or agencies, providing any HCBS service:

1. Provide services according to the plan of care and in a quality manner.
2. Coordinate provision of services in a cost-effective and quality manner.
3. Maintain beneficiary's independence and health, when possible, in a safe and dignified manner.
4. Communicate beneficiary's concerns, needs, changes in health status, etc. to the case manager within 48 hours including any ongoing reporting as required by Kansas Medical Assistance Program.
5. Any failure or inability to provide services as scheduled in accordance with the plan of care must be reported immediately to the case manager.
6. At least 95 percent of beneficiaries receiving services through the home health agency will report overall satisfaction with access, quality, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Signature

Date

Provider Compliance Attestation Form

This letter of attestation is being provided on behalf of the following individual or business entity:

Individual/Business Name and
Physical Address: _____

Telephone Number: _____

Contact Person: _____

1. Please indicate the type of building in which the business resides:
 - a. Free-standing building
 - b. Storefront (a store or other establishment that has frontage on a street or thoroughfare)
 - c. Professional office building with multiple office suites
 - d. Other (please specify): _____
2. Please indicate the business hours of operation: _____
3. What type of services are provided (medical, pharmaceutical, equipment/medical supplier, personal care, etc)? _____
4. Is the place of business closed for lunch and/or deliveries? Y N
5. Is the place of business ADA accessible? Y N
6. Is there a sign indicating the presence of the business clearly visible at the entrance? Y N

The provider agrees to comply with all state and federal laws, regulation, and professional standards applicable to services and professional activities provided to KMAP beneficiaries.

Under penalty of perjury, I certify by my signature the information provided is accurate. I also certify I am a duly authorized representative of the individual or business entity named above.

Provider Signature: _____

Printed Name: _____

Title: _____

Date: _____



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From the office of the Fiscal Agent

Do you use a billing agent and/or clearinghouse for any Kansas Medicaid function? ____ Yes ____ No

If yes, provide the following information:

Billing Agent (if applicable)

Entity Name: _____

Entity Address: _____

Direct Contact Name: _____

Direct Contact Number: _____

Direct Contact Email Address: _____

Clearinghouse (if applicable)

Entity Name: _____

Entity Address: _____

Direct Contact Name: _____

Direct Contact Number: _____

Direct Contact Email Address: _____



K A N S A S

Kansas Medical Assistance Program

Provider Agreement

1. Provider's Name	2. Physical Address (street, city, state & zip)
3. Pay-to Name (if different than information given in No. 1)	4. Pay-to Address (street, city, state & zip)

Terms and Requirements

1. Rules, Regulations, Policies

The provider agrees to participate in the Kansas Medical Assistance Program (KMAP) and to comply with all applicable requirements for participation as set forth in federal and state statutes and regulations, and Program policies, within the authorities of such statutes and regulations, of the Kansas State Medicaid Agency (SMA) as published in the KMAP Provider Manuals and Bulletins. The provider also agrees to comply with all state and federal laws and regulations applicable to services delivered and professional activities.

The provider agrees that the KMAP General Provider Manuals and the Provider Manuals specific to the program and services, Provider Manual revisions and Provider Bulletins are a part of this agreement and are wholly incorporated by reference. The provider agrees to read them promptly. The Manuals represent Medicaid program limitations and requirements that providers must follow to receive payment and to continue participation in the Medicaid program under K.A.R. 30-5-59(c)(1). The Manuals are in addition to the requirements of the Medicaid Provider Agreement and any other contracts such as managed care contracts and contracts with other insurance carriers. The fiscal agent for the KMAP has prepared the Manuals for the SMA, but the requirements and limitations in the Manuals are the official requirements and limitations of the relationship between providers and the SMA. Please use the Manuals whenever billing or communicating with the KMAP.

The Manuals make available to Medicaid providers informational and procedural material needed for the prompt and accurate filing of claims for services rendered to KMAP consumers. The Manuals are not a complete description of all aspects of KMAP. Should a conflict occur between Manual material and laws and regulations regarding the KMAP, the latter takes precedence.

From time to time, program policies will change. The SMA will notify the provider in the form of bulletins and revised Manual pages published on the KMAP Website, and upon publication of those revised Manual pages, the contract between providers and the SMA is amended. It is important that all revisions be placed in the appropriate section of the Manual and obsolete pages removed when applicable. You may wish to keep obsolete Manual pages to resolve coverage questions for previous time periods.

The Manuals represent the official policy and interpretations of regulations of the SMA in the administration of the KMAP. No provider may claim, in any judicial or administrative proceeding or hearing, that the SMA modified or interpreted the Manuals based simply on an oral conversation unless such interpretation or modification was reduced to writing and signed by the Secretary of the SMA. The fiscal agent for the KMAP has no authority to modify or interpret the Manuals.

(Note: The provider must read the General Provider Manuals and all other applicable Provider Manuals before providing services to beneficiaries. Providers must follow documentation standards contained in the manuals beginning on the first date of service.)

2. Ownership Disclosure

The provider agrees that all required ownership and operating information is fully and truthfully disclosed on the Disclosure of Ownership and Control Interest Statement which is included as part of the Provider Application.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or the U.S. Department of Health and Human Services (HHS) full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS full and complete information about any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS a full and complete updated Disclosure of Ownership and Control Interest Statement.

3. Change of Ownership

The provider agrees to report and disclose all required changes in ownership and operating information and that any reported or unreported changes may affect the status of this provider agreement. The provider agrees to report such change of ownership to the fiscal agent for the KMAP within thirty-five (35) days. Changes of ownership or tax identification number terminate this agreement and the new owner or provider must reapply and submit an updated Disclosure of Ownership and Control Interest Statement.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

4. Enrollment

An individually enrolled provider agrees that each provider performing services (except those services performed under the personal direction of an enrolled provider) must be individually enrolled in the KMAP and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to Kansas Medical Assistance consumers by the non-enrolled provider will be denied or, if paid in error, recouped by KMAP.

5. Internal Revenue Service (IRS) Reporting

The provider agrees that the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS and that as a member of a group practice an individual provider, billing as an individual rather than as a member of a group, cannot use the FEIN of the group practice. The provider acknowledges that the KMAP will report income to the IRS using only the SSN or FEIN of the billing provider or payee and that no income will be reported using the SSN or FEIN of the performing provider.

6. License, Certification, Registration

The provider agrees to maintain required licensed, certified or registered status for all categories for which participation is sought.

7. Record Keeping and Retention

The provider agrees that standardized definitions, accounting, statistics and reporting practices which are widely accepted in the provider field shall be followed and that all records necessary to disclose fully the payments claimed and services rendered shall be accurately maintained in a manner which is retrievable for a period of five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. The provider agrees that this record keeping requirement is not a limit on the ability of the SMA to recoup overpayments; overpayments can be recouped beyond the five year limit.

8. Access to Records, Confidentiality and Routine Review

The provider agrees that routine reviews may be conducted by the Department of Health and Human Services, the SMA, or its designee of services rendered and payments claimed for KMAP consumers and that during such reviews the provider is required to furnish to the reviewers records and original radiographs and other diagnostic images which may be requested. If the required records are retained on machine readable media, a hard copy of the records must be made available when requested. The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. Providers shall follow all applicable state and federal laws and regulations related to confidentiality.

9. Claims for Services Rendered

The provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to KMAP for payment. The provider agrees that the services listed on all claims are medically necessary for the health of the patient and are personally furnished by the provider or by the provider's employee under the provider's personal direction, the charges for such services are just, unpaid, and actually due according to federal and state statutes and regulations and Program policy, as announced in KMAP Provider Manuals and Bulletins and are not in excess of

regular fees; the information provided on the claim is true, accurate and complete; and the words “on file” or “signature on file” when placed on the KMAP claim refers to the provider’s signature on this document.

10. Timely Filing of Claims

The provider agrees that all claims must be received by the KMAP fiscal agent within twelve (12) months from the date the service was provided and that claims which are originally received within twelve (12) months from the date of service but are not resolved before the twelve (12) month limitation expires, may be corrected and resubmitted up to twenty-four (24) months from the date of service.

11. Payment

The provider agrees to accept as payment in full, subject to audit, the amount paid by the KMAP, with the exception of authorized co-payment and spenddown. The provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Program costs, payments may be pended or reduced and a payment plan as determined by the Secretary of the SMA will be developed within federal and state guidelines.

12. Billing the Consumer

The provider agrees that claims for covered services not submitted within twelve (12) months of the date of service, when the provider has knowledge of KMAP coverage, cannot be billed to the consumer and that claims which are timely filed and subsequently denied because of provider errors cannot be billed to the consumer if the provider fails to correct the errors and resubmit the claim. A provider may bill consumers for services not covered by KMAP if the provider notified the consumer of the non-coverage prior to the provision of services. The consumer must acknowledge the notification in writing.

13. Overpayment

The provider agrees that if it received payment for services or goods in an amount in excess of payment permitted by the KMAP that such overpayments may be deducted from future payments otherwise payable to the provider or the provider associated with the provider’s tax identification number or service location. The provider acknowledges that such remedy is not the only or exclusive remedy available to the SMA and that collection of the overpayment begins after its right to Administrative Review has been exhausted.

If funds have been overpaid or disallowed, the provider shall, within thirty (30) days of discovery by the provider or notification by the SMA or its agent, repay or make arrangements to repay on other terms approved by the SMA to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a provider of medical services and legal action by the SMA to recover such funds, including the legal rate of interest.

14. Fraud

The provider agrees that payment of claims is from federal or state funds, or both, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable federal or state laws. The provider acknowledges that he/she is accountable for claim information submitted personally by them or by their authorized employee regardless of the media by

which the provider submits claims. The provider acknowledges that the submission of a false claim, cost report, document or other false information, charging the recipient for covered services except for authorized spenddown and co-payment, and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable federal and state laws. Among such applicable laws is K.S.A. 21-3844 et.seq. and amendments thereto (the Kansas Medicaid Fraud Control Act).

15. Termination

The provider agrees that the SMA may terminate a provider's participation in the Kansas Medical Assistance Program for noncompliance with one or more terms of this provider agreement or applicable state and federal laws and regulations. Among such applicable regulations are K.A.R. 30-5-60 and 42 CFR § 455 et. seq.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

16. Civil Rights and 504 Compliance Assurances

The provider understands that the SMA policy is to comply with the applicable nondiscrimination, equal opportunity and affirmative action provisions of various federal and state laws, regulations and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. The provider understands that this compliance policy covers employment policies, practices, services, benefit programs and activities. The provider understands that the SMA will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the basis of race, color, national origin, ancestry, religion, age, sex, disability or political affiliation.

The provider shall agree: (a) to observe the provisions of the Kansas Act Against Discrimination and to not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, disability unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisements for employees, to include the phrase, "equal opportunity employer/service provider," or a similar phrase to be approved by the Kansas Human Rights Commission; (c) if the provider fails to comply with the manner in which the provider reports to the commission in accordance with the provisions of K.S.A. 44-1031, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; (d) if the provider is found to have committed a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Human Rights Commission that has become final, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; and (e) the provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor.

The provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin. The provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations are at 45 Code of Federal Regulations, Part 80.)

The provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of

disability. (Specific regulations found at 45 Code of Federal Regulations, Part 84.) The provider assures that all services will be provided in compliance with the provisions of the Americans With Disabilities Act of 1990, which prohibits discrimination on the basis of disability. (Specific regulations are at 29 Code of Federal Regulations, Part 1630.)

The provider assures that all services will be provided in compliance with the provisions of the Age Discrimination in Employment Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations are at 45 Code of Federal Regulations, Part 90.)

17. Professional Standards

The provider agrees to comply with all state and federal laws, regulations, and professional standards applicable to services and professional activities provided to KMAP consumers

18. Provider Agreement Term and Effective Date

This Provider Agreement shall be continuous and ongoing as long as the provider meets the requirements for participation in the KMAP including periodic reenrollment as required by the SMA. The provider agrees that this Provider Agreement is effective if all requirements for enrollment are met on the date of signing by the provider, or may be effective no more than twelve (12) months prior to the signing if a claim for covered services has been received by the KMAP fiscal agent. If all requirements are not met, the date on which such requirements are met shall be the effective date of this Provider Agreement.

19. Signature of Provider:

I certify by my signature, under penalty of perjury, that I am the individual named in Box 1, page 1, or I am duly authorized by the person listed in Box 1, page 1, to bind such person to the terms of this Provider Agreement and that I have read and understand the Provider Agreement and all applicable Provider Manuals and Bulletins.

Provider signature:

By: _____

Printed Name: _____

Title: _____

Date: _____

Acceptance by the Secretary of the State Medicaid Agency

By _____
Manager, Kansas Medical Assistance Program Provider Enrollment

Date _____



STATE OF KANSAS

Disclosure of Ownership and Control Interest Statement

Name of Entity/Individual	EIN/SSN	Date of Birth (if ind.)	NPI	Taxonomy
Address		City/ST		Zip Code

Questions 1 – 3 to be answered by fiscal agents and by all providers EXCEPT individual practitioners. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

1. Provide the following information for each person (individual or corporation) with an ownership or control interest in the provider/fiscal agent/managed care entity or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more.

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

1.a. For each corporation above, please provide the following:

NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.

Tax Identification Number	Primary Business Address

1.b. For each corporation above, please provide the following:
NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.

Every Business Location	Every P.O. Box Address

2. Is any person named in question #1 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s).
NOTE: Designate relationship to each person listed in question #1 by using 1.A., 1.B., 1.C., etc.

Yes
 No

Name	Relationship

3. Does any person named in question #1 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or entity.
NOTE: Designate relationship to each person listed in question #1 by using 1.A., 1.B., 1.C., etc.

Yes
 No

Name	Address	Tax Identification Number

Questions 4 – 14 to be answered by ALL providers. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

4. Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, please provide the following information below.

NOTE: A managing employee is a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.”

Yes
 No

Name	Description

5. Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period? If yes, give the information below for each subcontractor.

Yes
 No

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

5.a. Provide the following for all persons with an ownership or control interest in each subcontractor named in question #5.

Note: Designate relationship to subcontractor listed above by using 5.A, 5.B, 5.C, etc.

Name	Address	Date of Birth	Social Security Number

6. Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? If yes, give the information below for each wholly owned supplier or subcontractor.

Yes
No

Name	Address	Description of Business Transaction

7. Please provide the following information on all managing employees of the provider.

NOTE: Please see question #4 for the definition of a managing employee.

Name	Address	Date of Birth	Social Security Number
A.			
B.			
C.			
D.			
E.			

8. Have <u>any</u> of the individuals listed in questions #1 - 7 ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, please provide the following information below.			Yes <input type="checkbox"/>
			No <input type="checkbox"/>
Name	Program	State	

8.a. Have any of the individuals in question #8 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, please provide the following information below.			Yes <input type="checkbox"/>
			No <input type="checkbox"/>
Name	Program	State	

8.b. Do any of the individuals listed in question #8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes <input type="checkbox"/>
				No <input type="checkbox"/>
Name	Program	State	Amount of Debt	

9. Does any family or household members of any of the individuals listed in questions #1 - 8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.

NOTE: Designate relationship to each person listed in this question by using 1.A., 1.B., 5.A, 5.B., etc.

Yes
No

Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt

10. Have any of the individuals listed in questions #1 – 9 had any of the following healthcare related adverse legal actions imposed by Medicaid or any other Federal agency or program:

- Criminal Conviction
- Program Exclusion
- Civil Monetary Penalty
- Program Debarment
- Restitution Order
- Pending Criminal Judgment
- Administrative Sanction
- Suspension of Payment
- Assessment
- Criminal Fine
- Pending Civil Judgment
- Judgment Pending Under False Claims Act

If yes, please provide the following information below and attach copy of the adverse legal action notification(s).

Yes
No

Name	Program	State	Action

<p>11. Have <u>any</u> of the individuals listed in questions #1 – 10 had any of the following non-healthcare related adverse legal actions:</p> <ul style="list-style-type: none"> • Criminal Conviction • Program Exclusion • Civil Monetary Penalty • Program Debarment • Administrative Sanction • Suspension of payment • Assessment <p>If yes, please provide the following information below and attach copy of the adverse legal action notification(s).</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Name	Program	State	Action

<p>12. Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, please provide the following below.</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Name of Provider or Entity	Address of Provider or Entity	Tax Identification Number of Provider or Entity

<p>13. Please provide the following information for the contact person for audit purposes.</p>
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Name	Address	Phone Number	Title

<p>14. Please provide the address for the physical location of the records required to be kept under K.A.R. 30-5-59. P.O. Boxes and drop boxes are not acceptable.</p>
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Address	City/ST	Zip Code

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 WILL ONLY CONSIDER APPROVAL OF APPLICANTS THAT IT DETERMINES TO HAVE MET 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 _____



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

Submit Kansas Medical Assistance Program Claims Electronically

Benefits to submitting claims electronically include:

- Claims adjudicate within hours
- Cost savings in postage, paper, and ink
- Reduced time in claim preparation

Benefits to submitting electronic claims directly to the fiscal agent include:

- Submitters only need to contact the fiscal agent for submission problems; there are no intermediaries.
- Claim adjudication occurs within hours when submitting directly to the fiscal agent; intermediaries often transmit claims the next day.
- No fees are associated with submissions to the fiscal agent.

The fiscal agent offers two free solutions for electronic claims.

KMAP secure website – Claims can be filed online using the secure website. Claim adjudication occurs within seconds and allows any mistakes on a claim to be corrected and resubmitted. Beneficiary eligibility, claim status, prior authorization, pricing, and pharmacy NCPDP services are also available. Use of the KMAP secure website does not require an EDI application or an authorization test.

Provider Electronic Solutions – This batch billing software allows a batch of institutional or professional claims to be uploaded to the KMAP secure website. Claim adjudication occurs within hours. Beneficiary eligibility, claim status, prior authorization, and pharmacy NCPDP transactions can also be created. Use of batch billing software requires an EDI application and an authorization test. Call 1-800-933-6593 for details.

Other electronic claims solutions include:

Third-party software – A provider can select a software that meets his or her needs. An EDI application and authorization test are required before submitting claims for payment. The electronic claims clearinghouse (intermediary) must be authorized with the fiscal agent. Call 1-800-933-6593 for details.

For any questions regarding electronic claims or authorization testing, please contact the EDI Help Desk at 1-800-933-6593 or by e-mail at LOC-KSXIX-EDIKMAP@external.groups.hp.com.

RESOURCES

Provider Enrollment

785-274-5914

Provider Assistance Unit

785-274-5990

Toll Free: 800-933-6593

Beneficiary Assistance Unit

Toll Free: 800-766-9012

Adult Protective Services

(Form PPS 10400)

<http://www.dcf.ks.gov/services/PPS/Pages/10000Forms.aspx>

Kansas Bureau of Investigation

<http://www.accesskansas.org/kbi/criminalhistory/>

Motor Vehicle Screen

(Copy of driving record)

<http://www.ksrevenue.org/vehicle.htm>

National Provider Identifier

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

HCBS/FE policy manuals & online exams for Targeted Case Management

Frail Elderly (for TCM-FE enrollment only)

<http://www.kdads.ks.gov/index.html>

Kansas Department for Aging and Disability Services

Uniform Assessment Instrument (UAI) Training

(for TCM-FE enrollment only)

<http://www.kdads.ks.gov/index.html>

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Electronic Funds Transfer (EFT)

The State of Kansas offers electronic deposit to providers who request this service. Electronic deposit provides the highest degree of certainty that payments will be delivered securely, without the delays that can occur with paper warrants.

To sign up for electronic deposit, an Authorization for Electronic Deposit of Vendor Payment form must be completed and returned to the Kansas Department of Health and Environment, Division of Health Care Finance.

To request a form be mailed or faxed, please call:

Customer Service
785-274-5990 (local) or 1-800-933-6593

If you have questions completing the form, please call:

Kansas Department of Health and Environment, Division of Health Care Finance
785-296-3981 (Ask for the finance department.)