Kansas Medical Assistance Program

KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

HCBS-FE Adult Day Care

PART II
ADULT DAY CARE PROVIDER MANUAL

INTRODUCTION TO THE HCBS/FE PROGRAM Updated 11/03

The Home and Community Based Services for the Frail Elderly (HCBS/FE) Waiver Program is designed to meet the needs of consumers age 65 and older who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those individuals with the desire to live outside of an institution.

- Adult Day Care
- Assistive Technology
- Attendant Care Services
- Nursing Evaluation Visit
- Personal Emergency Response
- Respite Care
- Sleep Cycle Support
- Wellness Monitoring

All HCBS FE waiver services require prior authorization through the plan of care process.

Enrollment:

All HCBS/FE providers must enroll in the Kansas Medical Assistance Program and receive a provider number for HCBS/FE services. Contact EDS for enrollment.

NOTE: EDS supplies manuals for each HCBS/FE program in which the provider is enrolled.

HIPAA Compliance

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required 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.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. ADULT DAY CARE BILLING INSTRUCTIONS Updated 11/03

Updated 11/03

Introduction to the HCFA-1500 Claim Form

Providers must use the HCFA-1500 claim form (unless submitting electronically) when requesting payment for medical services provided under the Kansas Medical Assistance Program. An example of the HCFA-1500 claim form is shown at the end of this manual. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 claim form to providers. Refer to Section 1100.

Complete, line by line instructions for completion of the HCFA 1500 is available in the General Billing manual, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571

7010. ADULT DAY CARE SPECIFIC BILLING INSTRUCTIONS Updated 9/04

Enter diagnosis code 780.99 in field 21 on the HCFA-1500 claim form.

Enter procedure code S5101 (Day Care Services) in field 24D of the HCFA-1500 claim form.

One unit = One to five hours and no more than two units in a twenty four hour period.

Client Obligation:

If a case manager has assigned client obligation to a particular provider and informed that provider that they are to collect this portion of the cost of service from the client, the provider will not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Overlapping Dates of Service:

The dates of service on the claim must match the dates approved on the Plan of Care and cannot overlap.

Example:

An electronic Plan of Care has two detail lines items: the first line ends on the 15th of the month and the second line begins on the 16th with and increase of units.

A claim with a line item for services dated 8th thru 16th, will deny because it conflicts with the dates that have been approved on the electronic Plan of Care. At this time the claims system is not able to read two different lines on the Plan of Care for one line on a claim.

For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month, will be accepted by the system and not deny because of a conflict in the dates of service.

Services for multiple months should be separated out and each month submitted on a separate claim.

Same Day Service:

For certain situations, HCBS services approved on a plan of care and provided the same day a consumer is hospitalized or in a nursing facility may be allowed. Situations are limited to:

- HCBS services provided the date of admission, if provided PRIOR to consumer being admitted
- HCBS services provided the date of discharge, if provided FOLLOWING the consumer's discharge
- HCBS Targeted Case Management provided 30 days prior to discharge

Emergency Response Services

8000. Updated 2/05 BENEFITS AND LIMITATIONS

ADULT DAY CARE:

This service is designed to maintain optimal physical and social functioning for HCBS customers. This service provides a balance of activities to meet the interrelated needs and interests (*e.g.*, social, intellectual, cultural, economic, emotional, physical) of HCBS customers.

This service includes:

- Basic nursing care as delegated by the registered professional nurse and as identified in the service plan.
- No more than two (2) meals per day, excluding special dietary requirements.
- Daily supervision/physical assistance with certain activities of daily living limited to eating, mobility and may include transfer, bathing and dressing as identified in the service plan.

LIMITATIONS:

- Service may not be provided in the customer's own residence ("residence" includes Assisted Living Facilities, Residential Health Care Facilities and Home Plus).
- Customer service worksheet is subject to approval by the provider prior to implementation to ensure the provider is capable of meeting the customer's needs.
- Service is limited to a maximum of two units of service per day, one or more days per week.
- RN consultant must be available on-call as needed.
- Special dietary needs are not required but may be provided as negotiated on an individual basis between the customer and the provider. No more than two meals per day may be provided.
- Transfer, bathing, toileting and dressing are not required but may be provided as negotiated on an individual basis between the customer and the provider as identified in the individual's plan of care and if the provider is capable of this scope of service.
- Therapies (physical, occupational and speech) and transportation are not covered under this service but may be covered through regular Medicaid.

ENROLLMENT:

Providers must be licensed by the Kansas Department on Aging. Licensed entities include free-standing Adult Day Care Facilities, Nursing Facilities, Assisted Living Facilities, Residential Health Care Facilities, and Home Plus.

REIMBURSEMENT:

One unit = one to five hours and no more than two units in a twenty-four hour period.
Maximum unit cost = $20.67
Procedure Code = S5101 (Day Care Services)

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery; provide consistency with other Medicaid services such as Home Health Aide visits; and to meet customer preferences in providers and service delivery methods. Customer will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the plan of care regardless of the length of time needed to deliver service.

8000. Updated 2/05

Documentation Requirements:
Written documentation is required for services provided and billed to the Kansas Medical Assistance Program. Documentation at a minimum must consist of an attendance record. This record must include the following:

- ***Identify the waiver service being provided***
- **Customer's initials each visit if using an attendance record covering more than one day**
- **Customer's** name ***and*** signature, at a minimum each week
- Name ***and*** signature of ***authorized staff member***
- Date of service (MM/DD/YY)
- Start time for each visit; ***include AM/PM or utilize2400 clock hours***
- Stop time for each visit; ***include AM/PM or utilize 2400 clock hours***

This record must be generated and maintained during the time frame covered by the document. Generating documentation after-the-fact is not acceptable.

Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

Signature Limitations

In all situations the expectation is that the consumer provides oversight and accountability for people providing services for them. Signature options are provided in recognition that a consumer's limitations make it necessary that they be assisted in carrying out this function. A designated signatory may be anyone who is aware services were provided. The individual providing the services **cannot** sign the timesheet on behalf of the consumer.

Each time sheet must contain the signature of the consumer or designated signatory verifying that the consumer received the services and that the time recorded on the timesheet is accurate. The approved signing options include:

1. Consumer's signature,
2. Consumer making a distinct mark representing their signature,
3. Consumer using their signature stamp or,
4. Designated signatory.
5.

In situations where there is no one to serve as designated signatory the billing provider establishes, documents and monitors a plan based on the first three concepts above.

Consumers that refused to sign accurate time sheets when there is no legitimate reason, should be advised that the attendants time may not be paid or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned timesheets are a matter for the billing provider to address.

Expected Service Outcomes For Individuals or Agencies Providing HCBS/FE Services

Updated 11/03

1. Services are provided according to the Plan of Care and in a quality manner and as authorized on the Notice of Action.

2. Coordinate provision of services in a cost-effective and quality manner.

3. Maintain consumers' independence and health where possible, and in a safe and dignified manner.

4. Communicate consumer concerns/needs, changes in health status, etc., to the Targeted Case Manager or Independent Living Counselor within 48 hours including any ongoing reporting as required by the Medicaid program.

5. Any failure or inability to provide services as scheduled in accordance with the Plan of Care must be reported immediately, but not to exceed 48 hours, to the Targeted Case Manager or the Independent Living Counselor.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)