KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

General Introduction
PART I
GENERAL INTRODUCTION
KANSAS MEDICAL ASSISTANCE PROGRAM

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FORMS
All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp under Pricing and Limitations.

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PREFACE

This manual is part of the contract between enrolled providers and the Kansas Health Policy Authority (KHPA). This manual represents Medicaid program limitations and requirements providers must follow to receive payment and to continue participation in the Medicaid program under K.A.R. 30-5-59(c)(1). This manual is in addition to the requirements of the Medicaid Provider Agreement and any other contract with such as the HealthConnect contract. The fiscal agent for the Kansas Medical Assistance Program (KMAP), prepared this for KHPA, but the requirements and limitations in this manual are the official requirements and limitations of the relationship between providers and KHPA.

Please keep this manual in a looseleaf binder and use it whenever billing or communicating with KMAP.

This manual makes available to Medicaid providers informational and procedural material needed for prompt and accurate filing of claims for services rendered to KMAP beneficiaries. The manual is not a complete description of all aspects of the Medicaid program. Should a conflict occur between manual material and laws and regulations regarding KMAP, the latter takes precedence.

From time to time, program policies will change. KHPA will send the provider notification in the form of bulletins and revised manuals. Upon publication of those revised manuals, the contract between providers and KHPA is amended. All bulletins and manuals, including historical versions, are available on both the public and secure portions of the KMAP website. 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.

This manual represents the official policy and interpretations of regulations of KHPA in the administration of KMAP. No provider may claim, in any lawsuit or administrative hearing, that KHPA modified or interpreted this manual based simply on an oral conversation unless such interpretation or modification was reduced to writing and signed by the executive director of KHPA. The fiscal agent for KMAP has no authority to modify or interpret this manual except in the normal course of making formal revisions.

The manual is divided into two parts. Part I contains general information pertinent to all providers. Part II contains information specific to a particular provider type, such as dental, physician, or pharmacy.
INTRODUCTION TO THE KANSAS MEDICAL ASSISTANCE PROGRAM

Updated 05/10

KMAP is designed to assist the indigent in obtaining medical care. Medicaid is funded by a combination of state and federal monies. MediKan is financed solely through state funds.

KHPA is responsible for the administration of KMAP. All programs must operate according to the laws and regulations of the State of Kansas. Because the Medicaid program receives federal monies, it must also abide by the regulations of the Department of Health and Human Services.

Each provider performing services, including those within a group practice, must be individually enrolled in KMAP. Therefore, as group practices enroll or as new providers join a group, each individual must enroll separately. If individual providers within a given group fail to enroll, payment to the group will be denied or recovered.

Payments to all providers are subject to the limitations of KMAP. Should funds budgeted for the fiscal year prove inadequate to meet all costs on the basis of fees and charges, payment to providers will be pended; a payment plan as determined by the executive director of KHPA will be developed within federal guidelines.

Kansas Health Policy Authority
900 SW Jackson, Room 900
Topeka, Kansas 66612
785-296-3981
1000. CUSTOMER SERVICE  Updated 05/10

Questions regarding claims resolution and disposition and/or KMAP benefits and limitations should be directed to Customer Service.

Telephone Inquiries
Customer Service representatives can be reached at the following telephone numbers from 8:00 a.m. to 5:00 p.m., 7:30 a.m. – 5:30 p.m. Monday through Friday.

In-State Toll-Free Line 1-800-933-6593
Local Line 785-274-5990

The caller should have his or her provider number and all pertinent information available at the time the call is placed. Business calls may be monitored or recorded at any time for the purpose of ensuring the accuracy and quality of information provided.

The Electronic Data Interchange (EDI) department has information regarding various methods of electronic services available to providers. Contact the EDI department at 1-800-933-6593.

Written Inquiries
Written inquiries should be mailed to the following address:

KHPA Medical Plans
Office of the Fiscal Agent
Attn: Written Correspondent
P.O. Box 3571
Topeka, Kansas 66601-3571
1010. PROVIDER REPRESENTATIVES Updated 05/10

Provider Representatives are available to educate providers on acceptable billing methods and procedures within the Kansas Medical Assistance Program. Educational visits are conducted throughout the State of Kansas in the form of General Workshops, Provider Type Specific Workshops, and individual provider visits.

**General Workshops** are designed for providers who are new to billing Kansas Medical Assistance Program claims or who feel they need additional billing assistance. 'General Workshops' focus on general billing guidelines and available billing resources. 'General Workshops' schedules are mailed to the provider community each quarter.

**Provider Type Specific Workshops** focus on the more experienced biller and is hosted by the provider at his/her request or identified as needing training. 'Provider Type Specific Workshops' allow providers in the same geographic area who may have similar billing concerns to meet at one location with a EDS provider representative. A small group of no more than 20 providers allows more individual training with a personal approach.

A Medicaid provider representatives territorial map indicating each representatives phone number. Provider representatives can be contacted Monday through Friday can be found on the web site in the provider education section.
1100. FORM REORDERING  Updated 05/10

Providers must use EDS Form #60-7 to order Pharmacy claim forms and the Prior Authorization form. Other items such as the Adjustment form and KAN Be Healthy form should be duplicated from the provider manual.

EDS does not provide the CMS-1500 or UB-04 claim forms. Both forms must be obtained from a claim form supplier.

Forms and sample claim forms are on the public and secure websites at the following links:
- https://www.kmap-state-ks.us/Public/forms.asp

All forms can be duplicated for use except the CMS-1500, UB-04 and Pharmacy Claim forms.

To order Pharmacy claim forms, providers must send their requests to the following address:
Office of the Fiscal Agent
Document Management Department
P.O. Box 3571
Topeka, KS  66601-3571

The fiscal agent does not provide the CMS-1500, UB-04, or ADA Dental Claim forms. They must be obtained from a claim form supplier. Listed below are names and addresses of vendors who supply these forms. This list is not an inclusive list.

CMS-1500

Administrative Services of Kansas, Inc.
(A subsidiary of Blue Cross and Blue Shield of Kansas, Inc.)
P.O. Box 3500
Topeka, KS  66601-0110

CMS-1500 and UB-04

Advantage Business Forms
211 Southwest 6th
Topeka, KS  66603
785-235-6868

ADA Dental Claim Forms

American Dental Association
Attention: Catalog Sales
211 East Chicago Avenue
Chicago, IL  60611
1-800-947-4746
www.adacatalog.org
Introduction to the Automated Voice Response System

The Automated Voice Response System (AVRS) is an automated inquiry system allowing providers with a touch-tone telephone to access automated information to inquire about one or all of the following:

- Beneficiary eligibility for a given date of service
  
  **Note:** When the beneficiary is eligible, the AVRS indicates whether or not the beneficiary is eligible for Medicaid, MediKan, or in spenddown; is assigned a provider (HealthConnect); has other insurance; or has Medicare A and/or B.

- Number of office visits and therapeutic reserve days a beneficiary has used during the calendar year to date

- Eye examination within the last four calendar years for a beneficiary and the date eyeglasses, lenses and/or frames were dispensed

- The last KAN Be Healthy (KBH) medical screen date on file and the next possible date for a KBH medical screen (can be a date in the past), and the last dental, vision, and hearing screen dates on file

- Status of claims filed and payment inquiry

Office visit usage information as well as the date of the last paid eye examination will reflect the most current information from claims processed at the time of inquiry. Additional claims from other providers could be submitted and paid before your claim submission.

The AVRS is available seven days a week, 24 hours a day with scheduled maintenance and is only down from 1:00 a.m. to 2:00 a.m., Monday through Saturday, and 1:00 a.m. to 5:00 a.m. on Sunday.

**INSTRUCTIONS FOR ACCESSING AVRS**

*(for touch-tone telephones only)*

Call 1-800-933-6593.

**Identify yourself:** When prompted, enter your 10-digit KMAP provider number followed by a pound (#) sign (example: 0123456789#).

**Enter your request:** When prompted, enter the transaction code desired.

**For numeric eligibility on date of service, enter:**

- Transaction code 1 followed by a pound sign (example: 1#)
- Beneficiary’s 11-digit identification (ID) or Social Security number followed by a pound sign (example: 00123456789#)
- Date of service (MMDDYY) followed by a pound sign (example: 060195#)
1200. Updated 05/10

For office visit and therapeutic reserve days usage in current calendar year, enter:
- Transaction code 2 or 20 (for a new transaction for the same beneficiary) followed by a pound sign (example: 2# or 20#)
- Beneficiary's 11-digit ID or Social Security number followed by a pound sign (example: 00123456789#)
- Date of service (MMDDYY) followed by a pound sign (example: 060195#)

Note: If you have already accessed transaction 1 for this beneficiary, it is not necessary to re-enter the beneficiary ID number; just enter 20#.

For eye examination request and date of last eyeglass dispensing, enter:
- Transaction code 3 or 30 (for a new transaction for the same beneficiary) followed by a pound sign (example: 3# or 30#)
- Beneficiary's 11-digit ID or Social Security number followed by a pound sign (example: 00123456789#)
- Date of service (MMDDYY) followed by a pound sign (example: 060195#)

Note: If you have already accessed transaction 1 or 2 for this beneficiary, it is not necessary to re-enter the beneficiary ID number; just enter 30#.

For KBH screen, enter:
- Transaction code 4 or 40 (for a new transaction for the same beneficiary) followed by a pound sign (example: 4# or 40#)
- Beneficiary's 11-digit ID or Social Security number followed by a pound sign (example: 00123456789#)
- Date of service (MMDDYY) followed by a pound sign (example: 060195#)

Note: If you have already accessed transaction 1, 2, or 3 for this beneficiary, it is not necessary to re-enter the beneficiary ID number; just enter 40#.

For claim status/payment inquiry, enter:
- Transaction code 5 or 50 (for a new transaction for the same beneficiary) followed by a pound sign (example: 5# or 50#)
- Your 10-digit KMAP provider number followed by a pound sign (example: 0123456789#)

For National Drug Code (NDC) information, enter:
- Transaction code 6 followed by a pound sign (example: 6#)
- The eleven-digit NDC followed by a pound sign (example: 01234567121#)

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GENERAL INTRODUCTION PROVIDER MANUAL

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Introduction to EVS

Beneficiary eligibility information can also be accessed through an on-line or point-of-service (POS) eligibility verification system (EVS). Through a personal computer and modem or terminal and modem dialing a toll-free number, providers can enter any of three combinations to verify eligibility information.

- Beneficiary ID number and date of service
- Beneficiary Social Security number and date of service
- Beneficiary name, date of birth, and date of service

Eligibility information including KBH screening information, managed care participation, and additional insurance information will be displayed.

PICS on-line users can access claim status inquiry, provider financial summary, claim adjustment request, prior authorization requests, and additional inquiry services.

Contact Customer Service at 1-800-933-6593 for questions on beneficiary eligibility information.

For more information regarding how to access eligibility, providers can contact the EDI department at 1-800-933-6593, option 3.

POS devices or software supplied by the following vendors may also be used to access the above eligibility information: Emdeon, NDC, QS1 and ERX.
ICD-9-CM Diagnosis Coding

KMAP requires that claims submitted by providers using HCPCS procedure codes include a valid and specific diagnosis code as published in the ICD-9-CM coding books. The address for ordering the ICD-9-CM book can be ordered from Ingenix at innovate@ingenix.com or 1-800-765-6613.

Med-Index Publications
5225 Wiley Post Way
Suite 500
Salt Lake City, Utah 84116-2889
1-800-999-4600

National Correct Coding Initiative

The Centers for Medicare & Medicaid (CMS) developed the National Correct Coding Initiative (NCCI) to promote consistent coding methodologies and to control improper coding and inappropriate payment of claims. There are two types of NCCI code pair edits:

- Column 1/Column 2 edits (referred to as Correct Coding edits in MMIS) identify codes that should not be billed together because one service inherently includes the other.
- Mutually exclusive edits identify codes that for clinical reasons are unlikely to be performed on the same patient on the same day.

CMS updates the NCCI edits on a quarterly basis. The revised edits are incorporated into MMIS on the same quarterly schedule. When procedures submitted on a claim match code pair edits found on the NCCI tables, the claim is processed according to the edit parameters. In some cases, appropriately applied modifiers may be used to bypass the edits.

For more detailed information on the NCCI edits, the following resource is available: http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

CPT Procedure Coding

Many Medicaid providers are instructed to use CPT® codes when available. CPT® coding manuals are available through the American Medical Association at the following address:

American Medical Association
Order Department
P.O. Box 930876
Atlanta, GA 31193
1-800-621-8335
www.amabookstore.com
1400. GLOSSARY  Updated 05/10

ACH  adult care home
ACIL  Attendant Care for Independent Living
ALS  advanced life support
ARNP  advanced registered nurse practitioner
AVRS  Automated Voice Response System
AWP  average wholesale price
BCBSKS  Blue Cross and Blue Shield of Kansas
BLS  basic life support
CMS  Centers for Medicare & Medicaid Services
CMS-1500  health insurance claim form (medical)
CMHC  community mental health center
CPT  Current Procedural Terminology
DME  durable medical equipment
DOS  date of service
DUR  drug utilization review
EAC  estimated acquisition cost
EMC  electronic media claims
EDI  electronic data interchange
EOB  explanation of benefits
EOMB  explanation of Medicare benefits
EVS  eligibility verification system
FP  family planning
FQHC  federally qualified health center
FUL  federal upper limit
H&E  Department of Health and Environment
HCBS  Home and Community Based Services
HCPCS  Healthcare Common Procedure Coding System
HCPMP  Health Care Policy/Medical Policy
HHA  home health agency
HHS  Department of Health and Human Services
HIC  health insurance claim
HMO  health maintenance organization
ICD-9-CM  International Classification of Diseases - Ninth Revision, Clinical Modification
ICF/MR  intermediate care facility for mental retardation
ICN  internal control number
IM  income maintenance
IOC  inspection of care
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>KAECSES</td>
<td>Kansas Automated Eligibility and Child Support Enforcement System</td>
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<tr>
<td>KHPA</td>
<td>Kansas Health Policy Authority</td>
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<tr>
<td>LEA</td>
<td>local education agency</td>
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<tr>
<td>LTC</td>
<td>long term care</td>
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<tr>
<td>MARS</td>
<td>Management and Administrative Reporting System</td>
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<tr>
<td>MACSC</td>
<td>Medical Assistance Customer Service Center</td>
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<tr>
<td>MCD</td>
<td>Medicaid</td>
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<tr>
<td>ME</td>
<td>medical eligibility</td>
</tr>
<tr>
<td>MKN</td>
<td>MediKan</td>
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<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<tr>
<td>MN</td>
<td>medical necessity</td>
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<tr>
<td>MP</td>
<td>medical programs</td>
</tr>
<tr>
<td>MR</td>
<td>medical review</td>
</tr>
<tr>
<td>NC</td>
<td>noncovered</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>NF</td>
<td>nursing facility</td>
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<tr>
<td>NF/MH</td>
<td>nursing facility for mental health</td>
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<tr>
<td>NOC</td>
<td>not otherwise classified</td>
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<tr>
<td>OTC</td>
<td>over-the-counter</td>
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<tr>
<td>PA</td>
<td>prior authorization</td>
</tr>
<tr>
<td>PCCM</td>
<td>primary care case manager</td>
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<tr>
<td>QMB</td>
<td>qualified Medicare beneficiary</td>
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<tr>
<td>RA</td>
<td>remittance advice</td>
</tr>
<tr>
<td>ROE</td>
<td>report of eligibility</td>
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<tr>
<td>RTP</td>
<td>return to provider</td>
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<tr>
<td>SHS</td>
<td>special health services</td>
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<tr>
<td>SMAC</td>
<td>state maximum allowable cost</td>
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<td>SRS</td>
<td>Kansas Department of Social and Rehabilitation Services</td>
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<td>SSA</td>
<td>Social Security Administration</td>
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<td>SURS</td>
<td>Surveillance and Utilization Review Subsystem</td>
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<tr>
<td>STD</td>
<td>sexually transmitted diseases</td>
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<tr>
<td>TAD</td>
<td>turnaround document</td>
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<tr>
<td>TPL</td>
<td>third party liability</td>
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<tr>
<td>TPR</td>
<td>third party resources</td>
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<tr>
<td>UB-04</td>
<td>uniform billing 04 (hospital claim form)</td>
</tr>
<tr>
<td>UR</td>
<td>utilization review</td>
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