# PART I
GENERAL BENEFITS
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](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](https://www.kmap-state-ks.us/provider/security/logon.asp) under Pricing and Limitations.

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General Benefits

2000. Medicaid Updated 07/11

Introduction to Eligibility

Eligibility in Kansas is based on uniform statewide criteria. Eligibility information for each beneficiary is forwarded from the eligibility staff located in the regional offices and the Healthwave clearinghouse to the State of Kansas Department of Social and Rehabilitation Services (SRS) where it is incorporated into a central eligibility file. The State then sends an eligibility file to the fiscal agent. Each claim submitted by providers for payment processing is verified for beneficiary eligibility. Unless an individual is identified as eligible for the date of service submitted, payment cannot be made for a Medicaid or MediKan claim.

Plastic Medical Card

Every individual Kansas Medical Assistance Program (KMAP) beneficiary receives a plastic State of Kansas Medical Card. The plastic medical card contains three key pieces of information: member name, member ID, and member date of birth. The plastic medical card will only be reissued if there is a change in member name or member ID. If the beneficiary becomes eligible after more than 12 months of ineligibility, a new plastic medical card will be issued. Cards can be replaced if requested by the beneficiary in certain situations.

Eligibility information does not appear on the plastic medical card. Providers are responsible for verifying eligibility and coverage before providing services. Possession of a card does not guarantee eligibility. Changes in eligibility, assignment, spenddown amounts, level of care, copayment amount, and other coverage indicators may occur. Verification at the time of each service is extremely important. It is possible for a beneficiary to present a card during a period of ineligibility. A provider may check eligibility using the following methods:

- **Magnetic Swipe Technology**
  - The plastic medical card uses the same swipe technology used for credit cards.
  - This technology allows providers to use a card reader and a service provider to automatically access real-time beneficiary eligibility information through MMIS.

- **AVRS (Automated Voice Response System)**
  - This resource automatically provides the beneficiary’s eligibility over the telephone.
  - It is available 24 hours a day, seven days a week.
  - The entire call takes less than one minute.

- **AVRS Faxback**
  - This resource sends a fax to the provider’s fax machine with the beneficiary’s eligibility listed.
  - The fax service is available 24 hours a day, seven days a week.

- **Secure KMAP Website**
  - The secure KMAP website allows staff with authorization to conduct real-time eligibility verifications.
  - Staff simply enters the beneficiary’s ID and the date of service.
  - This service is available 24 hours a day, seven days a week.
• Customer Service
  o Eligibility can be verified by calling KMAP Customer Service at 1-800-933-6593 and speaking with an agent.
  o This service is available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

The Kansas Health Policy Authority (KHPA) was merged into the Kansas Department of Health and Environment (KDHE) and given the new name, Division of Health Care Finance (DHCF). Due to this transition, newly issued medical cards have the new KDHE-DHCF logo. Cards with both the KHPA and the new KDHE-DHCF logos can be accepted by providers. Providers are always responsible for verifying eligibility and coverage before providing services.

Below are examples of both versions of the plastic State of Kansas Medical Card, and an explanation of the information included on the front and back.

- The front of the card contains the member name, member ID and member date of birth (DOB).
- The back of the card contains a magnetic stripe, as well as important information for both the beneficiary and the provider.

Filing Proof of Eligibility
When a claim is denied "beneficiary ineligible for date(s) of service" on the remittance advice (RA) and you have proof of KMAP eligibility, attach eligibility documentation, along with an explanation of the problem, to the Eligibility Assistance Form. Any of the following documentation is acceptable for proof of KMAP eligibility:
  • A verification number from the Beneficiary Eligibility Verification System (BEVS) accessed from the AVRS or point of sale (POS) inquiry
  • A print out from POS BEVS
When your only proof of Medicaid eligibility is the verification number received from AVRS, indicate this number on your claim or attachment(s) and submit for special handling to:

Office of the Fiscal Agent  
P.O. Box 3571  
Topeka, KS  66601-3571

Assistance Obtaining Medicaid ID Number
Request beneficiary eligibility information through AVRS, using the eligibility instructions outlined in Section 1210 of the General Introduction Provider Manual, or POS BEVS, using the eligibility instructions provided in the accompanying manual.

Copayment

Federal guidelines allow states to require a copayment (a share of the cost of certain services) for which the KMAP beneficiary must pay.

Federal law mandates that a provider cannot deny services to a beneficiary because he or she is unable to pay the current or prior copayment. Providers may ask whether the beneficiary is able to pay the copayment amount at the time of service. If the beneficiary states an inability to pay the copayment, providers must accept this statement and may not collect the copayment from the beneficiary at that time.

Inability to pay copayment at the time of service does not remove the beneficiary's responsibility to make payment at a future time. Providers may offer payment plans to beneficiaries, if necessary.

Copayment Exemptions
The list below is not all inclusive. Refer to Section 8100 of your provider manual for copayment requirements applicable to services you provide.

Beneficiaries
- Residents in adult care homes, swing bed nursing facilities or Home and Community Based Services (HCBS)
- Beneficiaries under 18 years of age
- Beneficiaries 18 to 21 years of age, or 65 years of age or older, who are inpatients in a state psychiatric facility
- Beneficiaries enrolled in a Medicaid-funded health maintenance organization (HMO)
- Beneficiaries eligible for Medicaid due to a diagnosis of breast or cervical cancer
- Beneficiaries in out of home placement and in SRS or JJA custody at least 18 but under 21 years of age

General Services
- Alcohol and drug addiction treatment
- Family planning
- Services related to pregnancy
2000. Updated 07/11

- Attendant Care for Independent Living (ACIL)
- Indian Health
- Maternity center
- Emergency services (as defined by the diagnosis)
- Noncovered KMAP services
- Medical services related to an injury incurred on the job during a community work experience project
- Emergency medical services for aliens

**Spenddown**

In some cases, the income of a family or individual exceeds the income standard to receive public assistance monies. However, their income is not sufficient to meet all medical expenses. The family group/individual must then incur a specified amount of medical expenses before they are eligible for Medicaid benefits. This process is referred to as **spenddown**.

**Identifying Spenddown Beneficiaries**

Refer to Section 2000 for information on the plastic State of Kansas Medical Card and eligibility information.

**Claims Processed Against the Spenddown Amount**

The spenddown amount will be reduced by expenses for medically necessary services of eligible beneficiaries but not allowed for in the state Medicaid plan in one of two ways. Medicaid-enrolled providers may bill Medicaid for these services and the MMIS will deduct appropriately billed amounts from the appropriate spenddown, or the beneficiary can mail medical bills from non-Medicaid providers with proof of TPL resolution and these bills will be manually entered into the MMIS as beneficiary-billed claims.

The spenddown amount will be handled like a “deductible.” The MMIS will automatically credit the spenddown amount when Medicaid providers bill claims for medically necessary services. Billed charges apply to spenddown in date-processed order. Providers should bill all services regardless of whether they believe they are Medicaid-covered services so that all charges can apply toward spenddown.

Providers will be reimbursed for claims submitted for QMB-covered services rendered to QMB/Medically Needy dual eligibles. These services are not affected by unmet spenddown.

**Beneficiaries Responsibility**

Each time a provider-billed or beneficiary-billed claim is used to reduce the spenddown, the MMIS will identify the need for a notice to be sent to the beneficiary explaining which service(s) were used to credit the spenddown and what the new remaining spenddown amount is. These notices will be mailed to beneficiaries weekly. The beneficiary is responsible for the payment of all bills used to reduce their spenddown amount.

**Providers Reimbursement Maximized**

Each claim used to reduce a beneficiary’s spenddown amount will be flagged to identify whether the claim would have paid if spenddown had been met. In the event a claim is submitted which exceeds the amount of spenddown remaining, all claims for the beneficiary will be reviewed.
2000. Updated 07/11

Claims that are for noncovered services or for services that would not otherwise have been paid by Medicaid will be applied to spenddown first. Processed claims that would have paid if spenddown were met will be applied to spenddown in reverse date order. Once the spenddown amount is met, the fiscal agent will adjust any remaining payable claims so that the provider may receive reimbursement from the MMIS for the services rendered.
Introduction to the MediKan Program

The State of Kansas has a reduced set of benefits which covers beneficiaries receiving "General Assistance." These beneficiaries are only eligible for services provided under the assistance program entitled "MediKan." The MediKan program is designed to provide medical care in acute situations and during catastrophic illnesses for adults 18 years of age and older. There are no children (17 years of age or younger) in the MediKan program except for emancipated minors.

MediKan Benefits and Limitations

Medicaid and MediKan benefits and limitations are addressed separately in Part II of the program specific provider manual. Please refer to Section 8300 of the specific provider manual for detailed information regarding MediKan benefits and limitations. Although all basic Medicaid policies also apply to MediKan beneficiaries, it is important that Section 8300 is referenced to contrast the specific differences in coverage between Medicaid and MediKan.

Identifying MediKan Beneficiaries

See Section 2000 for complete information on plastic medical cards and eligibility verification.

Noncovered MediKan Program Areas

- Adult day treatment
- Behavior management
- Chiropractic
- Dental
- HCBS
- Intermediate/day treatment alcohol and drug addiction treatment facility services
- Nonemergency and nonambulance medical transportation
- Podiatry
- Vision services

Many other services are offered on a limited basis. (For example: DME - Wheelchairs are NOT covered for rental or purchase.) Check the specific provider manual for MediKan coverage information.

Prescription Drug Coverage

Pharmaceutical benefits for MediKan beneficiaries are limited to prescription drugs that have been accepted for inclusion on the MediKan specific formulary.
2030. QUALIFIED MEDICARE BENEFICIARIES Updated 07/11

Introduction to QMB
In accordance with the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, Medicare has expanded coverage to include catastrophic health care to those beneficiaries who are entitled to Medicare Part A benefits and who meet federal income criteria. Currently, the State of Kansas pays the Medicare premium, deductible and coinsurance for qualified Medicare beneficiary (QMB) individuals with some restrictions (see limitations listed below). These individuals fall into two categories, either those eligible for both QMB and Medicaid benefits or those eligible only for QMB benefits.

Identifying QMB Beneficiaries
See Section 2000 for complete information on plastic medical cards and eligibility verification.

QMB Benefits and Limitations
The QMB program enables payment of Medicare premiums, deductibles, and coinsurance (with some restrictions) for eligible beneficiaries.

Beneficiary eligibility benefits fall into two categories:
1. QMB Only
   - Medicare covered services only. Medicaid considers paying the Medicare coinsurance and deductible, but the total payment the provider receives will never be more than the Medicaid allowed amount.
   - QMBs are not eligible for payment of claims for Medicaid services which Medicare does not cover.
2. Medicare (QMB) + Medicaid (Dual Eligible)
   - Medicare covered services. Medicaid considers paying the Medicare coinsurance and deductible, but the total payment the provider receives will never be more than the Medicaid allowed amount.
   - Medicaid services. Dual eligibles are eligible for payment of Medicaid services not covered by Medicare. Claims are subject to the normal Medicaid limitations described below.

In either case of QMB coverage, if Medicare covered a service, Medicaid program limitations do not apply and are bypassed in the MMIS.

Medicaid Program Limitations
- Prior authorization (PA) requirements
- KBH requirements
- Medical assessment review

Some services Medicare covers are not a Medicaid-covered service. The QMB program requires Medicaid to consider the coinsurance and deductible on a claim, even if Medicaid does not cover the service. Medicaid will never pay for non-Medicaid covered services received by anyone not in the QMB program.
For information on state copayment requirements as they apply to QMB, refer to Section 2000.

Billing QMB Claims
File claims for QMB services in accordance with standard Medicaid billing practices. (Guidelines regarding Medicare assignment remain the same. Refer to Section 3200 of the General TPL Payment Provider Manual.) All required claim information must be present, valid and correct or the claim will deny. Refer to Section 7000 in Part II of the provider manual for specific details.

Low Income Medicare Beneficiaries Program
Medicaid also administers the Low Income Medicare Beneficiaries (LMB) program as part of the above federal authorization and the Balanced Budget Act of 1997. Under these provisions, beneficiaries are eligible for full or partial payment of Medicare premiums according to their income level. Participation in the program is transparent to providers, and there are no Medicaid benefits beyond premium payment.
Introduction to SOBRA - Emergency Medical Services for Aliens

Medical review of emergency services for establishing SOBRA eligibility are performed by the fiscal agent. Providers seeking coverage of emergency services for SOBRA beneficiaries must contact their local SRS office to initiate the eligibility process. Providers must complete Section II of the MS-2156 form (Medical Review of Emergency Services for Purposes of Establishing SOBRA Eligibility) and attach the form to medical records which document the emergent nature of the service(s) being billed for the beneficiary. This information must be mailed to:

Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

The records will be reviewed by designated fiscal agent staff and a determination made of the emergent nature of the service(s) based on criteria provided by the State. Once a determination is made, Section III of the MS-2156 form will be completed and forwarded to the local SRS office for completion of the SOBRA eligibility process. Once the local SRS office has completed the eligibility process and the beneficiary is determined SOBRA-eligible, the provider may file the claims specific to the service(s) and date(s) authorized. The only exception to this process is for labor and delivery. Covered services provided to the mother for the delivery of the infant will be approved at the local SRS office and will not require medical records review.

Services may be provided by physicians, dentists, ophthalmologists, laboratories, and radiologists. Allowable places of service are: inpatient hospital, emergency room hospital, office, outpatient hospital, Federally Qualified Health Clinic (FQHC), state or local public health clinic, Rural Health Clinic (RHC), ambulance, and laboratory. These services are to stabilize the emergency condition. Follow-up care or treatment for chronic conditions are noncovered.
2200. HEALTHCONNECT Updated 07/11

Introduction to HealthConnect Kansas

HealthConnect Kansas is a program administered by KDHE-DHCF to allow beneficiaries access to quality medical care in an efficient and economical manner. The HealthConnect Kansas primary care case manager (PCCM) agrees to provide medical care to a select group of KMAP beneficiaries or, when necessary, refer the patient to another provider. In the HealthConnect Kansas program, PCCMs are defined as providers who are:

- ARNPs
- Family practice physicians
- FQHCs
- General practice physicians
- Indian health centers
- Internal medicine physicians
- Local Health Departments (LHDs)
- Obstetrics and gynecology (OB/GYN) physicians
- Physician assistant (PA)
- Pediatric physicians
- RHCs
- Group practices of the provider types specified

Once a provider has become a PCCM, the provider will be asked to identify the clinical focus for the office. The current provider choice focuses are:

- Family Practitioner
- FQHC
- General Practitioner with Obstetrics
- LHD/Public Health Clinic
- Nurse Practitioner
- Pediatrician
- PA
- Family Practitioner with Obstetrics
- General Practitioner
- Internal Medicine
- Nurse Midwife
- (OB/GYN)
- Pediatrician and Internal Medicine
- RHC

The case manager is paid a monthly fee for each beneficiary assigned to his or her management, plus the established fee for service allowance for medical services provided. A beneficiary is restricted to his or her assigned case manager and cannot receive medical services from other providers without the case manager's approval. The only two exceptions are:

- Emergency services provided in the emergency room
- Services exempt from case management referral

The goals of HealthConnect Kansas are to:

- Better manage the beneficiary's use of medical services
- Provide access to primary and preventive medical care by the case manager on a 24-hour-a-day basis
- Contain costs in KMAP without a reduction in medically necessary services
- Improve continuity of care
2200. Updated 07/11

Primary Care Case Manager
To enroll in the HealthConnect Kansas Program as a PCCM, contact the Managed Care department at 1-866-305-5147 or send a written request regarding enrollment to the HealthConnect Kansas Program.

Office of the Fiscal Agent
Attn: Managed Care
P.O. Box 3571
Topeka, Kansas 66601-3571

Each HealthConnect Kansas case manager may contract to accept and provide primary care services for up to a maximum of 1800 beneficiaries. If a group enrolls, the total caseload can be 1800 beneficiaries per eligible case manager. The group may choose to accept a lesser number of beneficiaries, simply specify this at the time of enrollment.

Either the case manager or KDHE-DHCF may cancel the HealthConnect Kansas contract at any time by giving written notice 60 days in advance of the effective date of cancellation. Failure to provide written notice on the part of the case manager will result in forfeiture of monthly case management fees or recoupment of this amount if already paid by KDHE-DHCF for all months in which the PCCM did not render services.

Providers must not mail materials to beneficiaries directly, solicit beneficiaries to choose the provider as their case manager, or in any way attempt to influence a beneficiary as they choose a PCCM. Failure to comply with this directive may result in KDHE-DHCF enacting sanctions on the provider.

Enrollment of New Beneficiaries
When beneficiaries become eligible for Managed Care, they receive an enrollment packet asking them to choose a PCCM from the list of enrolled providers or a health plan (HealthWave 19 – HW19). Only providers who have agreed to become PCCMs and have not reached their chosen beneficiary maximum are available for selection. The beneficiary’s primary medical provider can be verified through any of the eligibility verification options. See Section 2000 of this manual for complete information on plastic medical cards and eligibility verification.

Beneficiaries in the voluntary populations may choose to participate in the Managed Care programs, but will not be defaulted/auto-assigned if they do not make a choice. The voluntary populations are as follows:

Children with special health care needs (CSHCN) – must be identified in the interChange MMIS as a child with special health care needs. The Kansas Department of Health and Environment (KDHE) is responsible for the CSHCN program. KDHE sends a file to the interChange MMIS identifying the CSHCN children. The CSHCN indicator in the interChange MMIS is set from the file received from KDHE. CSHCN can also request assignment to a provider outside the Managed Care Program. Many times this provider is a specialist with a specific set of skills and/or knowledge related to the child’s special health condition. There is a special contract these providers sign when agreeing to provide case management to a CSHCN participant. The CSHCN contract allows the provider to participate in the Managed Care Program for one CSHCN child.
2200. Updated 07/11

SSI children under the age of 21 – must be identified in the interChange MMIS as a child with an SSI beneficiary population code and under 21 years of age.

Beneficiaries of Native American descent – must be identified in the interChange MMIS as a beneficiary with an American Indian race/ethnicity code.

Beneficiaries in the voluntary populations will be sent a letter annually informing them that their participation in Managed Care is optional.

If beneficiaries meet one of the following exemption criteria they are exempt from Title XIX Managed Care:

- Beneficiary is in the lock-in program.
- Beneficiary has third party liability (TPL) requiring a case manager.
- Beneficiary is participating in one of the HCBS programs.
- Beneficiary resides in an adult care home.
- Beneficiary resides in a state institution.
- Beneficiary resides in an intermediate care facility for mental retardation.
- Beneficiary resides in a nursing facility for mental health.
- Beneficiary is in foster care.
- Beneficiary is participating in the adoption support programs.
- Beneficiary resides in a head injury rehabilitation facility.
- Beneficiary is enrolled with Medicare, including Qualified Medicare Beneficiary (QMB).
- Beneficiary is participating in the Health Insurance Premiums Payment System (HIPPS) program (exempt from HW 19 only).

Established Patients

When a practice is at their maximum caseload, it can submit the names of any established patients directly to the fiscal agent on the Enrollment/Disenrollment Form. The form must be completed, including the signature of both the provider and beneficiary or casehead of a minor. This form allows the fiscal agent to override the maximum caseload and add the beneficiary to the caseload without increasing the caseload permanently.

When a practice is not at maximum caseload, the beneficiary can follow the normal enrollment procedures outlined in the enrollment packet.

Regained Eligibility

Any beneficiary who is assigned to a PCCM's practice and loses KMAP eligibility for less than 60 days will be reassigned to the practice once KMAP eligibility is regained, if the practice has available slots. If no slots are available, the beneficiary will have to choose another primary care provider.

If KMAP eligibility lapses for more than 60 days and is then regained after 60 days, the beneficiary will be sent an enrollment packet and will be asked to choose a case manager or health plan through the ongoing process.
**Roster of Enrolled Beneficiaries**

Each PCCM is provided two monthly rosters of beneficiaries assigned to the practice. The first roster is mailed separately from the RA prior to the upcoming month; the second is sent around the fifth of each month. The rosters contain coverage information for each beneficiary. Due to HIPAA, TPL information is limited. Additionally, KBH information can no longer be made available on the roster.

HealthConnect (HCK) rosters and capitation payment listings are also available on the KMAP website. This free service allows HCK providers to access rosters and capitation payment listings quickly and easily.

To enroll, log on to the secure website and click “Request Online HealthConnect Rosters and Capitation Payment Listing”. Providers can choose to print the roster and capitation payment listing from the web. In addition, providers can store them on compact disk, local computer, or facility network for convenient retrieval. Previous web rosters and listings will continue to be available for up to two generations.

HCK rosters are available the fifth business day from the last day of the month for monthly rosters and around the fourth day of the month for semimonthly rosters. Capitation payment listings are available on the web the first of the month.

Providers who choose to receive their rosters and capitation payment listings through the KMAP website will no longer receive them by mail. The web versions are in the same format and contain the same information as the paper versions. Once this option is selected, the first web roster and capitation payment listing will appear the next available monthly cycle. Providers cannot receive both web and paper versions.

**Note:** HCK rosters and capitation payment listings prior to the selection date are not available on the web.

**Change of HCK Assignment**

Beneficiaries with assigned case managers are allowed to change their case manager at anytime. However, assignment changes can only be processed to take effect at the beginning of a month.

The Enrollment/Disenrollment Form is used to remove beneficiaries from a PCCM’s caseload. Provider’s requests to disenroll an assigned beneficiary must meet “Good Cause Reasons” and include supporting documentation on the form or in an attached letter. The following are “Good Cause Reasons” that allow a provider to disenroll a beneficiary.

- Beneficiary fails to keep appointments (after counseling).
- Beneficiary is abusive to provider, staff, or other patients.
- Beneficiary fails to follow medical advice (after counseling).
- Beneficiary was previously removed from provider's caseload.
- Case manager leaves the program.
- Fraud is suspected on case.

The Enrollment/Disenrollment Form also allows a PCCM to add beneficiaries when the provider reaches his or her caseload maximum. This request is considered authorization for the fiscal agent to override the maximum caseload. This will not result in a permanent change to the PCCM’s maximum caseload. The completed form and any required documentation and signatures should be faxed to 785-266-6109.
Contract Changes Requiring Notification to Fiscal Agent

Providers who contract with HealthConnect Kansas (HCK) need to notify the Managed Care department by phone at 1-866-305-5147 or by fax at 785-266-6109 when a change occurs in any of the following data elements as it relates to HCK participation:

- Tax ID number
- Clinic ownership
- Adding new providers to the office
- Retirement of providers from the office
- Providers going on sabbatical leave
- Closing the practice
- Providers leaving clinic
- Physical address
- Office hours
- Phone number
- Admitting privileges
- Age range of accepted patients
- Covering provider
- Panel size

By contacting the Managed Care department prior to a change in any of the above listed elements, a smooth transition for claims payment and beneficiary care is ensured.

Providers Terminating Their HealthConnect Kansas Contract

A provider who wishes to terminate his or her HealthConnect Kansas contract must provide written notice of the intent to terminate to KDHE-DHCF or the fiscal agent at least 60 days prior to the termination. Failure to provide 60-day written notice of the intent to terminate may result in the recoupment of the last two months of administration payments made to the provider, per the HealthConnect Kansas contract.

A provider discontinuing care must provide beneficiaries assigned to him or her medical services or give a referral to another KMAP provider for services until the beneficiaries are no longer assigned to the provider.

HealthConnect Case Manager Responsibilities

Responsibilities of the case manager are outlined in the PCCM contract that is signed by the provider at the time of enrollment. In general, the case manager agrees to:

- Provide the primary health care needs of the beneficiary by performing a physical assessment including a care plan
- Refer the beneficiary to other physicians or providers when necessary
- Monitor the service(s) delivered

The beneficiary should only be referred when the case manager is unable to perform a needed service, desires a second opinion, or will no longer be able to provide case management services.

Referrals are required for specified services, however a written referral form does not have to be exchanged between providers. All referrals should be documented in the beneficiary’s medical record with both the PCCM and the receiving medical provider to ensure the service was directed by the PCCM.

The case manager is expected to provide KBH services to beneficiaries under 21 years of age or refer the beneficiary to an appropriate medical provider or specialist as needed. The physician must agree to supervise the screening, diagnosis, and treatment of the beneficiary on an ongoing basis, including administering immunizations as needed. It is encouraged that immunizations be provided at the time of the screen; however, the beneficiary can be referred to the LHD for this service. (Refer to the KAN Be Healthy Provider Manual for complete information on the KBH program.)
Services Requiring Referral from the HealthConnect Primary Care Case Manager
The following nonemergency services are **not covered** if provided or prescribed by a provider other than the assigned PCCM unless the PCCM makes a referral.

- ARNP
- ACIL
- Audiology
- Dietitian
- Durable medical equipment
- Home health
- Hospice
- Inpatient hospital
- KBH screens (with exception of dental)
- LHD
- Medical supplies
- Non-CMHC partial hospitalization
- OB care when a beneficiary is assigned to an OB/GYN PCCM
- Podiatry
- Physical therapy
- Physician
- Prosthetic and orthotic items
- Psychiatry/psychology
- Vision surgery services performed in an inpatient setting (requires KBH)

Services Not Requiring Primary Care Case Manager Referral
Any provider can render emergency care in the emergency room due to illness or trauma without a referral from the PCCM. Any subsequent, nonemergent care does require a referral from the PCCM. When billing for care that might be classified as emergent, and the PCCM referral was not secured, the nature of the emergency must be documented in the medical record.

The following are common examples of services that **do not** require a referral:

- Adult care home (ACH)
- Alcohol and drug abuse community based services
- Ambulance (nonemergency)
- Anesthesia
- Assistant surgery
- Behavior management services outlined in the *Psychiatric Residential Treatment Facility Provider Manual*
- CMHC and non-CMHC affiliate providers
- Dental services including KBH dental screens
- Early Childhood Intervention (ECI)
- Emergency room services
- Family planning
- HCBS
- Immunizations
- Indian health centers
- Inpatient services for a primary TB-related diagnosis
2200. Updated 07/11

- LEA
- Laboratory
- Maternity center services
- Newborn home visits
- Pharmacy
- Prenatal Health Promotion and Risk Reduction service
- Psychiatric hospital stays or related physician and ancillary services provided during a psychiatric hospitalization approved through the preadmission assessment process
- Radiology
- Services provided for a covered pregnancy related diagnosis (on beneficiaries assigned to a PCCM other than an OB/GYN or an ARNP specializing in OB/GYN services)
- Services provided in an FQHC
- Sexually transmitted disease (STD) services
- State institution services
- Vision services (other than surgical services performed in an inpatient setting)

**Referral Requirements**

Referrals are required for specified services, however a written referral form does not have to be exchanged between providers. Documentation of the referral must be included in both the PCCM and receiving providers’ medical records for the beneficiary to ensure the service was directed by the PCCM.

Documentation of the referral must be available for review. Without referral documentation, reimbursement is subject to recovery. It is required that both the referred and referring providers maintain referral documentation in the medical record. Verbal referrals can be given but must be documented in the medical record. A referral is not needed for emergency room services.

Referral documentation in the PCCM medical record for the beneficiary must include the following information:
- Date of referral
- Reason for referral
- Where beneficiary is being referred
- Scope of referral

Referral documentation in the receiving provider’s medical records for the beneficiary must include the following information:
- Name of the referring provider
- Reason for referral
- Date of referral

When a receiving provider refers the beneficiary to additional providers, the PCCM shall be notified to ensure coordination of care with all involved providers. The coordination of care must be clearly documented in the medical records.
2200. Updated 07/11

HealthConnect Kansas Guidelines/Billing Instructions

Emergency Admissions
When inpatient services are the result of an emergency, documentation shall be maintained in the medical record supporting the nature of the emergency. Place the attending physician's Medicaid provider number in the first occurrence of field 76 on the UB-04 claim form. Providers should reference their electronic media resources to determine corresponding electronic claim fields.

Inpatient Admissions
When a PCCM admits his or her own patient, place the PCCM provider number in the “attending physician” field.
If another physician, who has received a referral from the PCCM, is admitting the beneficiary, the hospital must have documentation in the medical record supporting the PCCM’s assent for inpatient services. The “referring physician” field on the claim is not required.

Outpatient Services
Documentation in the hospital outpatient medical record must indicate the HealthConnect Kansas case manager's approval and the statement shall be signed by the individual who received the approval. If the HealthConnect Kansas provider cannot be reached, approval must be secured from one of his or her covering providers.

Peer Education and Resource Council (PERC)
The Peer Education and Resource Council (PERC) assists with provider education, development and review of improvement plans for providers, peer review, and recommendations for policy change. PERC is composed of Health Care Policy Medical Policy (HCPMP) representatives, fiscal agent representatives, and at least six enrolled KMAP providers. Providers on the council are chosen by HCPMP and represent a cross-section of providers from across the State of Kansas.
HealthWave XIX offers eligible Medicaid beneficiaries the choice to have their primary health needs provided through a physical health managed care organization (MCO) which serves as their primary care provider. Beneficiaries assigned to one of the medical MCO plans will receive both a plastic State of Kansas Medical Card and a card from the MCO plan. Providers should use both cards when verifying eligibility and coverage.

HealthWave XIX is available to adults and children under the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) women and children in active counties.

Individuals excluded from the HealthWave XIX program are:

- Beneficiaries with Medicare coverage
- Beneficiaries enrolled in another managed care program (e.g., HealthConnect)
- Beneficiaries who have another third party insurance with an MCO or case manager
- Beneficiaries residing in a:
  - Nursing facility
  - State institution
  - Nursing facility for mental health (NF/MH)
  - Head injured rehabilitation facility (HIRF)
  - Intermediate care facility for the mentally retarded (ICF/MR)
- Beneficiaries enrolled in any HCBS program
- Beneficiaries enrolled in the Health Insurance Premium Payment Service (HIPPS) program
- Beneficiaries in the lock-in program
- Beneficiaries eligible for foster care
- Beneficiaries eligible for adoption support programs
- Beneficiaries eligible for the breast and cervical cancer program
- Beneficiaries enrolled in the working healthy program

**Excluded Services**

The physical health MCO provides all primary health services and necessary, specialty services to its members, except for the services listed below. Some restrictions may apply. These are covered through Medicaid's traditional fee for service programs or another MCO.

- Alcohol and drug abuse services, except for medical detoxification in a hospital
- Services provided in a community mental retardation center
- Dental services, except for inpatient dental
- Long term care services:
  - Services provided in a nursing facility
  - HCBS
  - Services provided in an ICF/MR
  - Services provided in a NF/MH
  - Services provided in a HIRF
- Mental health services, including services by a psychiatrist or psychologist, community mental health center, partial hospitalization, and behavior management
- Services provided in a state psychiatric institution
Covered HealthWave XIX MCO Services
The following are the minimum services the MCO will provide. These services will be available to beneficiaries in the MCO's service area. Services can be provided by the MCO or through the MCO's subcontractors.

- Audiology and hearing
- Blood transfusions
- Chiropractic for KBH beneficiaries only
- Contraceptives
- Dietary
- Durable medical equipment
- Emergency services
- Family planning services
- Home health services
- Home visits for the newborn, including risk assessment of the newborn, instruction in parenting practices, and referral to other support services, if needed
  
  Note: One home visit per beneficiary within 28 days after the birth date of the newborn
- Hospice
- Inpatient hospital, including acute medical detoxification and inpatient dental
- Laboratory services that meet Clinical Laboratory Improvement Act standards
- Medical supplies
- Mental health medications
- Services provided by a mid-level practitioner
- Occupational therapy
- Outpatient hospital services
- Podiatry services for KBH beneficiaries only
- Pharmaceuticals, all except blood fractions
- Physical therapy
- Services provided by a physician
- Prenatal health promotion and risk reduction (risk assessment, counseling, instruction in prenatal care practices, including methods to control risk factors, instruction in effective parenting practices, referral to other support, if needed, and follow up)
- Radiology (X-rays)
- Screening, diagnosis and treatment of sexually transmitted diseases
- Speech therapy
- Transportation, emergency and nonemergency
- Vision
- KBH (EPSDT) services, screenings as well as medically necessary KBH extended services
Transportation Services
Depending on a beneficiary’s benefit plan, commercial nonemergency medical transportation (NEMT) services may be covered or noncovered. If a beneficiary is assigned to an MCO, commercial NEMT services are the responsibility of the beneficiary’s assigned medical MCO.

If a beneficiary has the following benefit plans, he or she qualifies for commercial NEMT services and is assigned to the NEMT broker, MTM, Inc.:
- TXIX (Title 19)
- QMB and TXIX
- MN (medically needy) with met spenddown
- P19 (Presumptive Title 19)
- P21 (Presumptive Title 21)

If a beneficiary has the following benefit plans, he or she does not qualify for commercial NEMT services:
- QMB only
- MediKan
- ADAP-D & ADAP-T (AIDS Drug Benefit Program)
- LMB & ELMB (Low-Income Medicare Beneficiary)
- SOBRA (Sixth Omnibus Bill Reconciliation Act)
- TB (Tuberculosis)
- TXXI (Title 21)

The following beneficiaries do not qualify for commercial NEMT services:
- Beneficiaries residing in a NF
- Beneficiaries with a PACE assignment
- Beneficiaries assigned to a HealthWave MCO

If a beneficiary is assigned to one of the following, he or she should be instructed to contact his or her assigned medical MCO to obtain commercial NEMT services:
- HW19 (HealthWave 19-MCO Title XIX)
- HW21/TXXI (HealthWave 21)

Trips excluded:
- Trips to WIC clinics
- Trips to LEAs
- Trips to educational classes or day care services
- Errands or shopping
- Trips to attend nutrition, diabetic or other informational classes
- Trips for noncovered services like breast enhancement or weight management

Sterilizations
The Medicaid MCOs are responsible for payment of sterilizations. The MCOs must ensure that a completed Sterilization Consent Form is available upon request.

Third Party Insurance
The Medicaid MCOs are responsible for collecting and reporting TPL from the third party insurance if services are provided by the Medicaid contracting MCO.
When a provider is located in a state other than Kansas, and services are rendered in that state, the provider must be licensed and otherwise certified by the proper agencies in his or her state of residence as qualified to render the services for which the charge is made. Certain cities, within 50 miles of the Kansas border, may be closer for Kansas residents than major cities in Kansas, and therefore these cities are considered Border Cities (see list below). This list is not all-inclusive. All others are considered out-of-state and require PA. (Refer to Section 4300 of the General Special Requirements Provider Manual.)

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KANSAS MEDICAL ASSISTANCE PROGRAM
GENERAL BENEFITS PROVIDER MANUAL

2-21
2400. PROGRAM INTEGRITY  Updated 07/11

Historically, in order to monitor quality of care, Medicaid used retrospective utilization review which looked at documentation of treatment related to specific episodes of care. Because Medicaid has altered the ways in which it purchases health care it has become necessary to reevaluate the quality management program. The primary catalyst for change has been the shift to managed care, and specifically, the inclusion of HMOs as service providers. Since reimbursement is through a capitation method under managed care, Medicaid must evaluate the overall health outcomes of the Medicaid population rather than looking only at treatment associated with specific episodes of care. The following components comprise the Medicaid outcome based quality management program and are being implemented according to the principles of continuous quality improvement.

Goals of the Medicaid quality management program are to:
- Improve the quality of health care provided to beneficiaries through a process of continuous quality improvement
- Improve beneficiary access to medically necessary services
- Encourage appropriate utilization of services and benefits

There are many processes and procedures utilized within the Medicaid quality management program which exist to protect the integrity of the program and the quality of services provided to the beneficiaries. Examples of these include the following:

**System Edits and Audits**
The claims processing system consists of edits and audits which automatically check each claim for accuracy and validity. In addition, claims are processed through rebundling software which identifies inappropriately unbundled codes and rebundles them to a code which is inclusive of the codes originally billed separately.

**Utilization Review**
Services reimbursed by Medicaid are subject to a manual review process in which medical professionals review documentation in the provider's records to ensure services were performed as billed and in quantity and form which reflects quality and generally accepted standards of care.

**Standards of Care**
Standards of care utilized by Medicaid include nationally recognized standards such as those recommended by the American Academy of Pediatrics regarding well-child visits which pertain to the Medicaid KBH program.

**Ineligible Providers**
An ineligible provider is defined as one who would not be eligible if application to be a provider was made, even though the service to be provided was covered. According to Kansas Administrative Regulation 30-5-67, KMAP shall not reimburse for claims generated by certain ineligible providers. Services ordered, prescribed, or performed by ineligible providers are not billable to KMAP and will not be reimbursed.
Medicaid also recommends initial prenatal visits occur as follows:

- First trimester, visit within 14 days of first request
- Second trimester, visit within seven days of first request
- Third trimester, visit within three days of first request
- High risk pregnancies, visit within three days of identification of high risk

Other standards utilized by Medicaid in the HealthWave XIX Kansas and HealthConnect Kansas programs include:

- Beneficiaries must have 24-hour access, seven days a week to medical advice.
- In-office appointment wait times must not exceed two hours from the time of the scheduled appointment.
- Urgent care appointments are provided within two days of when the beneficiary presents or calls with symptoms of sudden or severe onset.
- Routine preventive care appointments (non-KBH) are made available within 45 days of the beneficiary’s request.
- 85 percent of a provider’s KBH population is up-to-date on KBH screens for those beneficiaries who have been with the provider for one or more years.
- Remedies/corrective action plans are responded to by the provider within the time frames requested.

There are many standards against which Medicaid must measure clinical/nonclinical services. The above list is not considered exhaustive and is to be used as an example.

**Provider Satisfaction Surveys**
Written surveys occur on a yearly basis and are sent to all providers in the HealthConnect Kansas or HealthWave XIX Kansas programs. The intent of these surveys is to obtain feedback from providers in regard to program implementation and suggestions for improvement in program policies or processes.

**Consumer Satisfaction Surveys**
Yearly random sample telephone surveys are completed to determine the level of consumer satisfaction with the program in regard to access, quality of care, and barriers to obtaining services.

**Monitoring of Clinical/Nonclinical Data**
This includes ongoing analysis and trending of specific data indicators related to the health status of the Medicaid population. This may include issues involving access, quality or utilization.

**Studies**
Based upon the findings of surveys, complaints, utilization review or indicator analysis, further analysis may occur through implementation of a focused study. Studies will pertain to issues relevant to the Medicaid population and may include topics such as prenatal care, access, immunizations, pediatric asthma, or KBH. Individual Medicaid providers may have the opportunity to participate in these study processes thereby gaining knowledge of their own practices and assisting in shaping the future of quality in the Medicaid program.
2400. Updated 07/11

Education
As a result of findings through indicator analysis, surveys, complaints or studies, Medicaid will initiate education specifically targeted to the population most affected. This includes both providers and beneficiaries. It is the intent that through positive educational efforts and encouragement of continuous quality improvement for individual provider practices, punitive program actions may significantly decrease.

Committees
The Peer Education and Resource Council (PERC) - PERC is a group of currently practicing Medicaid health care providers whose purpose is to provide clinical and program education to HealthConnect Kansas providers and to recommend policy initiatives to the Medicaid program which enhance quality and access to services while controlling costs.

External Quality Review Advisory Committee - This advisory committee consists of medical directors from each of the participating HMOs, a PERC and Drug Utilization Review Board member and staff from within the Kansas Department of Health and Environment. The purpose of this committee is to assist Medicaid in developing, implementing and evaluating outcome based studies across all Medicaid programs.

Fraud and Abuse

Beneficiary
The SRS Legal Fraud Unit is responsible for the investigation and prosecution of beneficiary fraud. The Fraud Unit operates a 24-hour, toll-free fraud hot line telephone service, 1-800-432-3913. Suspected cases of beneficiary fraud (including the abuse of the medical ID card) should be immediately reported through the hot line.

Lock-in (Beneficiary Restriction)
Beneficiaries found to be abusing their medical coverage through a review of Medicaid claim history are educated as to more appropriate behavior. If abuse continues, beneficiaries are restricted to a specific provider(s) for a period of two years. This process is known as lock-in. If abusive patterns continue during the two-year period, or the beneficiary had previously been on lock-in, lock-in will be extended for an indefinite period of time. KDHE-DHCF may place beneficiaries on lock-in without education based on the severity of the abuse.

Normally a beneficiary will be locked-in to a pharmacy, physician, and/or hospital. In some cases, the beneficiary may be locked-in to all of these.

Lock-in information is available through BEVS via AVRS or POS system. See Section 2000 of this manual for complete information on plastic medical cards and eligibility verification.

When a provider believes a beneficiary is abusing the program by over-using (requesting services the provider deems not to be medically necessary, "doctor-hopping", or any excessive use of doctors, hospitals, emergency rooms, or drugs), it is requested that the provider assist the state agency in controlling such abuse. The provider can confront the beneficiary about unacceptable behavior, or the provider can choose to notify KDHE-DHCF of the abuse.
Abuse situations can also be communicated to:
KDHE-DHCF
900 Southwest Jackson, Room 900
Topeka, Kansas 66612
785-296-3981
Welfare Fraud Hotline 1-800-432-3913

**Lock-in Pharmacy**
The lock-in pharmacy is responsible for verifying that the prescribing physician is the lock-in physician. In the event that the prescribing physician is not the lock-in provider, the pharmacy must obtain a copy of the written referral given to the prescribing physician by the lock-in physician. A copy of the written referral must be kept in the pharmacy and be available upon request by KDHE-DHCF personnel.

When a lock-in pharmacy cannot fill a prescription (for example, out of stock), then the lock-in pharmacy must write a referral to another pharmacy to fill the prescription. This should be an exception and not be done on an on-going basis.

**Lock-in Physician**
The lock-in physician's role is similar to the PCCM in that a written referral is required from the lock-in physician before any other physician or specialist can be paid for services rendered. A month referral is allowed versus a six month referral. A referral to the same provider specialty may occur only if the lock-in physician does not have an appointment time available or is out of the office, such as vacation. A lock-in physician cannot refer to another physician to fulfill case management requirements.

Lock-in is initiated as a result of abuse of the medical card and may be initiated in any county. A case management fee is paid monthly to the lock-in physician. When a beneficiary is placed on lock-in, in most cases, the PCCM is retained as the lock-in physician and a case management fee is paid to the physician for the lock-in status.

**Lock-in Hospitals**
When a beneficiary is locked-in to a hospital, the beneficiary should use only that lock-in hospital. In a nonemergency situation, there must be a written referral from the lock-in physician for outpatient services. Emergency situations do not require a referral.

Also, if the beneficiary goes to a non-lock-in outpatient hospital for a nonemergency diagnosis, that outpatient hospital will not be paid. (The emergency room charge will not be paid for a nonemergency diagnosis regardless of the lock-in status.)

**Referral Requirements**
When a beneficiary is placed on lock-in, a written referral from the lock-in provider is required before another provider can be reimbursed for services rendered.

The written referral must be retained in the referred provider's office and in the pharmacy, and must be furnished on request. The referral must be dated and is only valid for one month immediately following its issue.
Billing Instructions

Services rendered by any provider in the event of a true emergency will be covered if documented appropriately.

Pharmacy: Enter the lock-in physician's 10-digit Kansas Medicaid provider number or NPI in the prescribing physician field for point of sale claims if the lock-in provider is the prescribing physician. If prescription privileges were referred, a paper claim must be submitted with the lock-in provider's number in the "Remarks Field" or a written referral attached to the claim.

Physician: Enter the KMAP lock-in provider number in field 17A of the CMS-1500 claim form unless the billing/performing provider is the lock-in provider or filing claims for radiologists or pathologists.

Hospital: Enter the KMAP lock-in physician's provider number in FL 76 of the UB-04 claim form.

Provider

The Medicaid Fraud and Abuse Division of the Office of the Kansas attorney general is responsible for the investigation and prosecution of provider fraud. All cases of suspected fraud should be reported immediately to the Division for investigation. Referrals can be made at any time by contacting the Division at 785-368-6220.

Prosecution will be under applicable state and/or federal law. Conviction can result in punishment that includes full restitution of the excess payments, payment of interest, payment of reasonable expenses and the costs of the investigation and prosecution, payment of fines and penalties, and imprisonment. The Division will also request KDHE-DHCF to take action to terminate provider participation in the Medicaid program.

Determination by the agency that abuse or fraud of the Medicaid program has occurred may result in suspension of payment, prepay review of claims, recoupment of monies, or termination of the provider's eligibility to participate in the Medicaid program.

Complaint/Grievance Process

Medicaid beneficiaries and providers who have concerns regarding access to care, utilization of services, quality of services, or rights and dignity can contact the fiscal agent at 1-800-933-6593 (in-state providers) or 785-291-4145 (Topeka area providers) between 8:00 a.m. - 5:00 p.m., Monday through Friday. Concerns will be carefully evaluated and directed to the appropriate staff for research, follow-up, and action if needed. You will be notified of the outcome.

If you have a concern about the health care provided to a Medicaid beneficiary or the quality of health care services of another provider, please notify the fiscal agent at the number above.

For issues concerning potential beneficiary fraud, please contact the fraud hotline at 1-800-432-3913.
2500. STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH PROVIDERS
Updated 07/11

Providers of services and supplies to beneficiaries must comply with all laws of Kansas and the regulations and policies of KDHE-DHCF and the standards or ethics of their business or profession in order to qualify as a participant in the program. The State Medicaid director or his/her designee may notify a provider of the intent to discontinue a provider's participation in KMAP.

Upon notification of intent to withdraw payment liability for services rendered, or to terminate participation in KMAP, the provider of services has the opportunity for an administrative review. If after the administrative review, the provider continues to disagree with the determination, a subsequent fair hearing may be requested with a hearing officer at KDHE-DHCF.

Kansas Administrative Regulation 30-5-60 states in part that the agency may terminate a provider's participation in KMAP for one or more of the following reasons:

- Pattern of submitting inaccurate billings or cost reports
- Pattern of unnecessary utilization
- Civil or criminal fraud against KDHE-DHCF or Social Service Programs or any other state's Medicaid or Social Service Programs
- Suspension by the secretary of Health and Human Services from the Title XVIII program for any reason
- Direct or indirect ownership or controlling interest of five percent or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the Medicare program or KMAP or Social Service Programs or any other state's Medicaid or Social Service Programs
- Employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the Medicare program or KMAP or Social Service Programs or any other state's Medicaid or Social Service Programs and other "good cause"
2600. REPORTING OF ABUSE, NEGLECT OR EXPLOITATION OF CHILDREN OR RESIDENTS IN ADULT CARE HOMES-REQUIRED Updated 07/11

Who Must Report
- Any person licensed to practice any branch of the healing arts
- The chief administrative officer of a medical care facility
- An adult care home administrator
- A licensed social worker
- A licensed professional nurse
- A licensed practical nurse

Any other person having reasonable cause to suspect or believe that a child or ACH resident is being or has been abused, neglected, exploited or is in a condition which is the result of such abuse, neglect, exploitation or is in need of protective services may report such information to their local SRS office.

Upon receipt of reports of abuse, neglect or exploitation in ACHs or medical care facilities (hospitals), SRS will refer all such complaints to the Kansas Department on Aging (KDOA), Adult Care Complaint Program. The complainant should be given the KDOA toll-free hot line number, 1-800-842-0078. Complaints received in writing will be forwarded to:

KDOA
Adult Care Complaint Program
New England Building
503 South Kansas Avenue
Topeka, KS  66603-3404

Reports of abuse, neglect or exploitation of adults or children in a home setting will be referred to SRS Children and Family Services. The complainant should be given the toll-free hot line number of Children and Family Services, 1-800-922-5330.

What Must Be Reported
- Information regarding the nature and extent of the abuse or neglect
- Name and address of the involved resident or child
- Name and address of the caretaker caring for the resident or child
- Name and address of the person making the report
- Name of next of kin of the resident or child, if known
- Any other information which the person making the report believes might be helpful in any investigation of the case and the protection of the resident or child

Immunity of Reporter
No person who makes such a report or who testifies in any administrative or judicial proceeding arising from such report shall be subject to any civil liability on account of such report or testimony, unless such person acted in bad faith or with malicious purpose.

No employer shall terminate the employment of, prevent or impair the practice or occupation of or impose any other sanctions on any employee solely for the reason that such employee made or caused to be made such a report.
2600. Updated 07/11

How To Report

Call KDOA at 1-800-842-0078 regarding reports of abuse, neglect or exploitation in adult care homes or licensed care facilities (hospitals), go in person, or write your local SRS office.

Call 1-800-922-5330 regarding abuse, neglect or exploitation in a home setting, go in person, or write your local SRS office.
2700. DOCUMENTATION REQUIREMENTS  Updated 07/11

Claim/Record Storage Requirements
K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for 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. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims through computerized systems must maintain these records in a manner which is retrievable.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers:

- To keep such records as necessary to disclose fully the extent of services rendered to beneficiaries
- To furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider

Providing medical records to KDHE-DHCF or its designee is not a billable charge.

Advance Beneficiary Notice
The KMAP beneficiary can be held responsible for payment of common services and situations. Beneficiaries can be billed only when program requirements have been met and the provider has informed the beneficiary in advance and in writing. The provider must notify the beneficiary in advance if a service will not be covered. To ensure the beneficiary is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the beneficiary prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.

K.A.R. 30-5-59, “…(e) Payment. Each participating provider shall meet the following conditions: (4) not charge any Medicaid/Medikan program beneficiary for non-covered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for non-covered services;”

Suggested content for the Advance Beneficiary Notice
This constitutes advance notice to you, the beneficiary, that if all program requirements are met by (the provider) and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid.

For services where there is normally no face-to-face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed annually by the beneficiary with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

- Beneficiary was not eligible when services were provided.
- Beneficiary was eligible when services were provided, however, did not inform the provider of his or her KMAP eligibility timely. (This action must have prevented the provider from filing services to the program within the timely filing guidelines outlined in Section 5100 of the General Billing Provider Manual.)
2700. Updated 10/11

- Services Medicaid does not cover, unless both of the following apply:
  - Beneficiary is a QMB.
  - Service is covered by Medicare.
- When other insurance does not reimburse the provider because there was lack of authorization.
- Abortions, unless continuation of the pregnancy will endanger the life of the mother, or when a pregnancy is the result of rape or incest.
- Any services related to and performed following a noncovered abortion.
- Acupuncture.
- Community mental health center services and alcohol and drug abuse treatment services provided outside the boundaries of Kansas regardless of being within 50 miles of the state border.
- Cosmetic surgery.
- Services related to and performed following a noncovered cosmetic surgery.
- Court appearances, telephone conferences/therapy.
- Educational/instructional services.
- Hypnosis, biofeedback, or relaxation therapy.
- Infertility services (any tests, procedures, or drugs related to infertility services).
- Nonrestorative (developmental) physical, occupational, or speech therapy.
- Occupational therapy supplies.
- Perceptual therapy.
- Psychotherapy for patients whose only diagnosis is mental retardation.
- Services for the sole purpose of pain management.
- Services provided in cases of developmental delay for purposes of "infant stimulation."
- Services which are pioneering or experimental, and complications from such services.
- Services of social workers, team or therapy coordinators, and speech therapists in private practice (unless beneficiary is a QMB).
- Transplant surgery.
  - Cyclosporine (except when prior authorized, following kidney, liver and bone marrow transplants).
  - All services related solely to noncovered transplant procedures.
- Transplant surgery, in some cases, is a covered service for a KMAP beneficiary. Call Customer Service for a list.
- Treatment for obesity. EXCEPTION: Orlistat (Xenical®) and sibutramine (Meridia®) will be covered with PA. Individuals with a body mass index (BMI) greater than 30 or greater than 27 with comorbidity may be eligible to receive orlistat or sibutramine with PA.
- Vocational therapy, employment counseling, marital counseling/therapy and social services.
- Voluntary sterilizations which do not meet federal requirements.
- Services provided to a MediKan beneficiary in the following program areas: alcohol and drug addiction treatment facility, behavior management, chiropractic, dental, Head Start facility, Local Education Agency, nonemergency and nonambulance medical transportation, podiatry, and vision.
- The private room difference in a hospital setting.
- Special diet in the hospital when ordered per the patient's request.
Providers are not to charge a KMAP beneficiary for services denied for payment by KMAP because the provider has failed to meet a program requirement including PA.

**Laboratory Services**
The drawing or collection fee is considered content of service of an office visit or other procedure and is not covered if billed separately. The beneficiary cannot be billed for the drawing or collection since it is considered content of another service or procedure.

*Note: Providers shall not bill beneficiaries for missed appointments. Missed appointments are not a distinct reimbursable service but a part of the providers’ overall cost of doing business.*

**Documentation Requirements**
As with all other insurance carriers, Medicaid has specific requirements regarding documentation of services performed and billed to KMAP. These requirements are within the standards of each professional scope of practice and are consistent with requirements of other major insurance carriers. The following information regarding documentation requirements is not new but is provided as education so each provider can ensure all services billed to Medicaid are medically necessary and have been provided as billed.

- The patient record shall be legible and **stand on its own**.
- The date and reason for a service must be included.
- Extent of the patient history and exam must be documented along with a treatment plan.
- Documentation must support the level of service billed.
- Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp which reflects results of the exam for each of the systems identified on the rubber stamp.
- Unless permitted by specific HCBS program guidelines, **check marks are not accepted**.
- Records must be created **at the time the service is provided**.

Progress notes must include:
- Chief complaints or presenting problems
- Type of history
- Extent of services
- Patient progress and response to treatment
- Evidence of the type of decision made which includes, but is not limited to:
  - Diagnoses
  - Treatment options
  - Extent of data reviewed
  - Risk of morbidity and mortality

The following questions should be asked to ensure appropriate documentation exists to support the level of service billed:

- Is the reason for the visit documented in the patient record?
- Are all services that were provided documented?
- Does the patient record clearly explain why support services, procedures, supplies and medications were or were not provided?
- Is the assessment of the patient's condition apparent in the record?
2700. Updated 07/11

- Does documentation contain information on the patient's progress and results of treatment?
- Does the patient record include a plan for treatment?
- Does information in the patient record provide medical rationale for the services and the place of service that are to be billed?
- Does information in the patient record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services? Is there documentation of timely referrals?

Recordkeeping responsibilities rest with the provider. When a service is not documented or documentation is not legible, the service is not reimbursed.

**Electronic Documentation Signature**
Electronic signatures that meet the following criteria are acceptable for Medicaid documentation:
- Identify the individual signing the document by name and title
- Include the date and time the signature is affixed
- Assure the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence
- Provide for nonrepudiation, that is, strong and substantial evidence that will make it difficult for the signer to claim the electronic representation is not valid

The use of an electronic signature is deemed to constitute a signature and has the same effect as a written signature on a document.

The provider must have written policies and procedures in effect regarding the use of electronic signatures. In addition to complying with security policies and procedures, the provider who uses computer keys of electronic signatures must sign a statement assuring exclusive access and use of the key or computer password. The policies and procedures and statement of exclusive use must be maintained at the provider’s location and available upon request by the State or fiscal intermediary.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider’s own internal policies.

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.

Original signatures are still required on provider enrollment forms.

**Electronic Documentation**
Electronic documentation that meets the following criteria are acceptable for Medicaid:
- Meet all documentation and signature requirements contained in the General Benefits Provider Manual
- Meet all documentation and signature requirements specific to the KMAP program and services provided
- Assure the documentation cannot be altered once entered
- Maintain a system to document when records are created, modified or deleted to provide an audit trail

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Providers must have written policies and procedures in effect regarding the use of electronic documentation that must be maintained at their location and available upon request by the State or fiscal intermediary. These requirements for clinical documentation apply only to Medicaid claims and do not preclude other state or federal requirements.

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.

*Note:* Documentation can be requested at any time to verify that services have been provided within program guidelines.

In the case of a postpayment review, reimbursement is recouped if documentation is not complete or does not meet the general documentation requirements provided in this manual and the requirements specific to the KMAP program and services provided. Refer to the provider-specific manual, including its benefits and limitations section and recordkeeping requirements, for additional documentation requirements.

To verify services provided in the course of a postpayment review, documentation in the beneficiary’s medical record must support the level of service billed. Documentation for the HCBS program must validate services billed were provided in accordance with the plan of care. Documentation for any KMAP program created after the fact is not accepted in a postpayment review.
2710. GENERAL THERAPY GUIDELINES AND REQUIREMENTS  Updated 07/11

Therapy services are covered when they are:
- Prescribed by a physician, as required by your license/certification.
- Medically necessary.
- Habilitative - Habilitative therapy is covered only for beneficiaries age zero to under the age of 21. Therapy treatments approved and provided by an ECI, Head Start or LEA program may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to maintain maximum possible functioning for children.
- Rehabilitative - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following debilitation due to an acute physical trauma or illness.
- Provided by a licensed physical or occupational therapist or a certified therapy assistant, working under the direct supervision of a licensed physical or occupational therapist. When services are performed by a certified therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed physical or occupational therapist initialing each treatment note written by the certified therapy assistant, or the licensed physical or occupational therapist writing “treatment was supervised” followed by his or her signature.

Therapy services are limited to six months for beneficiaries over the age of 21 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for beneficiaries age zero to 21.

Therapy codes should be billed as one unit equals one visit unless the description of the code specifies the unit.

Documentation requirements of therapy services:
- Pertinent past and present medical history with approximate date of diagnosis
- Date, time, and description of each service delivered and by whom (name, designation of profession or paraprofession)
- Identification of expected goals or outcomes and beneficiary’s response to therapy
- Progress towards goals

Please refer to your specific provider manual for additional benefits and limitations.
2720. TELEMEDICINE  Updated 11/11

Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.

Office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the codes listed below using the GT modifier and will be reimbursed at the same rate as face-to-face services. The originating site, with the beneficiary present, may bill code Q3014.

KMAP no longer recognizes AMA CPT® consultation codes (ranges 99241 – 99245 and 99251 – 99255) for payment. Any service previously billed with a consultation code should be billed with an available code that most appropriately describes the level of service provided.

If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may proceed in either one of the following ways:

- Bill the primary payer a CPT® evaluation and management (E&M) code that is appropriate for the service, and then report the amount actually paid by the primary payer along with the same E&M code to Medicaid for determination of whether payment is due.
- Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer along with an E&M code that is appropriate for the service to Medicaid for determination of whether payment is due.

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LIMITATIONS

- The patient (beneficiary) must be present at the originating site.
- Email, telephone and facsimile transmissions are not covered as telemedicine services.
- Documentation requirements are the same as face-to-face services, see Section 2710.
Hospice provides an integrated program of appropriate hospital and home care for the terminally ill patient. It is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. A hospice provides personal and supportive medical care for terminally ill individuals and supportive care to their families. Emphasis is on home care with inpatient beds serving as backup for the Home Care Program. Central to the hospice philosophy is self-determination by the patient in medical treatment and manner of death.

**Hospice Limitation**
Hospice services under the Medicaid benefit are limited to 210 days per lifetime, regardless of provider or place of service. Kansas Medicaid reimburses providers for two 90-day periods followed by one 30-day period.

**Waiver of Rights to Medicaid Payment**
The beneficiary waives all rights to Medicaid/MediKan payments for the duration of the election of hospice care for any Medicaid/MediKan covered services that are either:
- Related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Equivalent to hospice care except for services:
  - Provided directly or under arrangement by the designated hospice
  - Provided by another hospice under arrangement by the designated hospice
  - Provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services

**Services Not Related to the Terminal Illness**
Services normally covered under KMAP require PA when the beneficiary is a hospice beneficiary and the service does not relate to the terminal illness. Refer to Section 4300 of the General Special Requirements Provider Manual for information on obtaining PA.

**Note:** Hospice providers will not be required to obtain PA for targeted case management (TCM) when a beneficiary elects hospice services. Beneficiaries receiving hospice services may also be eligible to receive services through the HCBS program. However, HCBS may not duplicate services being rendered by the hospice provider.

To ensure services are not duplicated and the hospice beneficiary is receiving the quality of care that he or she is entitled to, KMAP may ask for written care plans from hospice and HCBS providers. Hospice is the coordinator of all care services that the hospice beneficiary receives. When a beneficiary is admitted to hospice services while receiving TCM services, providers do not need to obtain PA for TCM services. Care coordination provided through the hospice benefit and TCM are separate and distinct services and are not duplicative.

**Hospice Care for Children in Medicaid**
Beneficiaries receiving services reimbursed by Medicaid and Children’s Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled “Concurrent Care for Children,” allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.
The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Limitations
The 210-day-per-lifetime hospice limitation does not apply to children receiving hospice services. Hospice patients 0 through 20 years of age can receive necessary hospice services for the duration needed. The 210-day-per-lifetime limitation will begin on the beneficiary's 21st birthday.

Medical Services and Concurrent Care for Children Receiving Hospice Services
Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- PA is required.
- Hospice providers will be responsible for coordinating all services related to the hospice diagnosis and assisting nonhospice providers to obtain authorization for services not related to the hospice diagnosis in accordance with 42 Code of Federal Regulations 418.56.
- Hospice providers will be responsible for all durable medical equipment, supplies, and services related to the hospice diagnosis.
- Nonhospice providers must first communicate and coordinate with hospice providers regarding needed services or procedures prior to rendering concurrent care for children.
- Nonhospice providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, nonhospice providers must submit a paper claim, documentation of medical necessity and the hospice denial form to the PA department for review.
- If PA cannot be obtained prior to rendering services to children, providers may be allowed a backdated approval for services upon submission of a paper claim for the service with documentation attached to support medical necessity and hospice denial of the service.

Hospice patients (0 through 20 years of age) can receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an ARNP enrolled in KMAP
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all durable medical equipment and supplies.
2900. CHILDREN AND FAMILY SERVICES (CFS) CONTRACTORS  Updated 07/11

Medicaid mental health reimbursable services will not be paid by child welfare contractors. Covered services will either be paid on a fee-for-service basis or through the Prepaid Ambulatory Health Plan (PAHP) coverage.