Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

General Benefits

Updated 09.2017

PART I
GENERAL BENEFITS FEE-FOR-SERVICE
KANSAS MEDICAL ASSISTANCE PROGRAM

TABLE OF CONTENTS

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

General Benefits

2000. Fee-For-Service Medicaid Program and KanCare Updated 02/16

Introduction to Eligibility

Eligibility in Kansas is based on uniform statewide criteria. Eligibility determinations are made primarily at the KanCare Clearinghouse using the Kansas Eligibility Enforcement System (KEES). KEES 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

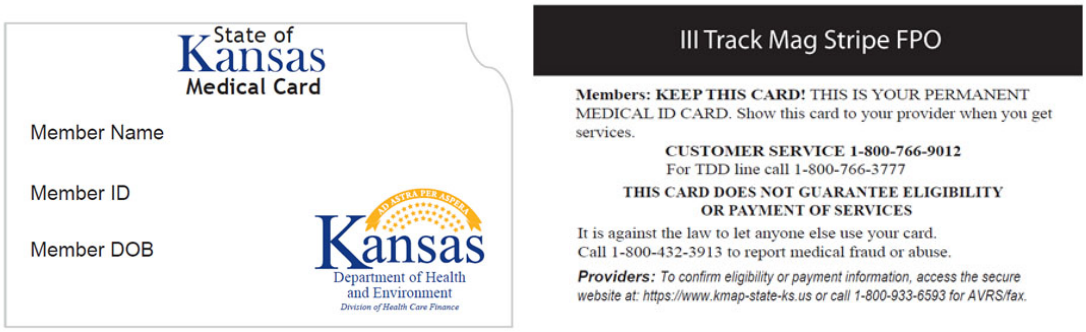
Most beneficiaries not assigned to a KanCare plan will receive a plastic State of Kansas Medical Card. The plastic medical card contains three key pieces of information: member name, member ID, and member date of birth. The plastic medical card will only be reissued if there is a change in member name 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. If a consumer is assigned to a KanCare health plan, they will only get an ID card from the assigned plan.

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**
  - Eligibility can be verified by calling KMAP Customer Service at 1-800-933-6593 and speaking with an agent.
  - This service is available between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday.

2000. Updated 02/16

Below is an example 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
PO 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 Fee-for-Service 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.

2000. Updated 07/13

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 Kansas Department for Aging and Disability Services KDADS or Kansas Department of Corrections (KDOC) custody at least 18 but under 21 years of age
- American Indian or Alaskan Native, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services

General Services

- Alcohol and drug addiction treatment
- Family planning
- Services related to pregnancy
- 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.

2000. Updated 03/13

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.

Providers enrolled with KanCare and Medicaid may bill Medicaid for these services and the system 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 system will automatically credit the spenddown amount when KanCare/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 KanCare/Medicaid-covered services so that all charges can appropriately 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.

Beneficiary Responsibility
Each time a provider-billed or beneficiary -billed claim is used to reduce the spenddown, the system 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.

Claims that are for noncovered services or for services that would not otherwise have been paid by KanCare/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 or KanCare health plan will adjust any remaining payable claims so that the provider may receive reimbursement for the services rendered.

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 a KanCare health plan, commercial NEMT services are the responsibility of the beneficiary's KanCare health plan.

If a beneficiary is assigned to a KanCare health plan, he or she should be instructed to contact his or her assigned KanCare health plan to obtain commercial NEMT services.

Trips excluded:
- Trips to WIC clinics
- Trips to LEAs
- Trips to educational classes or day care services

2000. Updated 09/17

- Errands or shopping
- Trips to attend nutrition, diabetic or other informational classes
- Trips for noncovered services like breast enhancement or weight management

Meals and lodging related to out-of-state or overnight travel may be reimbursed when deemed medically necessary by the beneficiary's health care professional or approved by the State's PA unit.

- For KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) children 20 years of age and younger, payment for lodging and meals for the beneficiary and one parent or guardian may be allowed daily. If the beneficiary is receiving inpatient services, meals for one parent or guardian will be reimbursed. In lieu of meals out, groceries may be reimbursed.
- For beneficiaries who are not KBH-EPSDT, payment for an attendant's meals and lodging may be allowed daily. If the beneficiary is receiving inpatient services, meals for one attendant will be reimbursed. In lieu of meals out, groceries may be reimbursed.
- The beneficiary may be instructed to contact and use facilities such as Ronald McDonald House and Via Christi Guest Lodging before other lodging is considered.

Sterilizations
The KanCare health plans are responsible for payment of sterilizations. The KanCare health plan must ensure that a completed Sterilization Consent Form is available upon request.

Third-Party Insurance
The KanCare health plans are responsible for collecting and reporting TPL from the third-party insurance if services are provided by the Medicaid contracting MCO.

2010. MEDIKAN Updated 09/14

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
- 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 03/13

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. KanCare/Medicaid considers paying the Medicare coinsurance and deductible, but **the total payment the provider receives will never be more than the KanCare/Medicaid allowed amount.**
    - KanCare/Medicaid services. Dual eligibles are eligible for payment of KanCare/Medicaid services not covered by Medicare. Claims are subject to the normal KanCare/Medicaid limitations described below.

In either case of QMB coverage, if Medicare covered a service, KMAP limitations do not apply and are bypassed.

Medicaid Program Limitations

- Prior authorization (PA) requirements
- KBH requirements
- Medical assessment review

Some services Medicare covers are not KanCare/Medicaid-covered services. The QMB program requires the fee-for-service Medicaid program to consider the coinsurance and deductible on a claim, even if Medicaid does not cover the service. The fee-for-service Medicaid program 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.

2030. Updated 07/13

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 Fee-for-Service 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.

2040. EMERGENCY MEDICAL SERVICES FOR ALIENS: SOBRA Updated 06/17

Introduction to SOBRA - Emergency Medical Services for Aliens

Medical review of emergency services for establishing Sixth Omnibus Budget Reconciliation Act (SOBRA) eligibility are performed by the fiscal agent. Providers seeking coverage of emergency services for SOBRA beneficiaries must contact the KanCare Clearinghouse at 1-800-792-4884. The consumer will be required to complete an application for KanCare. Once financial eligibility for Medicaid has been determined, the Clearinghouse will request that the provider 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
PO 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 KanCare Clearinghouse for completion of the SOBRA eligibility process. Once the Clearinghouse 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. For dates of service prior to July 31, 2017, all covered services provided to the mother for the delivery of the infant will be approved by the Clearinghouse and will not require medical records review. Effective with dates of service on and after August 1, 2017, all cesarean and complicated vaginal deliveries covered by SOBRA will require the MS-2156 form and medical necessity (MN) documentation to be submitted. With the exception of normal labor and delivery, all other services covered through the SOBRA benefit must have a completed MS-2156 form and MN documentation.

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.

2300. BORDER CITY/OUT-OF-STATE PROVIDERS Updated 07/13

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 Fee-for-Service Provider Manual*.)

ARKANSAS
Bentonville
Gateway
Gravette
Rogers

COLORADO
Arapahoe
Burlington
Campo
Cheyenne Wells
Eads
Eckley
Idalic
Joes
Kirk
Lamar
Lycan
Springfield
Stonington
Stratton
Vilas
Vona
Walsh
Wiley
Wray
Yuma

MISSOURI
Anderson
Appleton City
Asbury
Belton
Blue Springs
Burlington Junction
Butler
Carthage
Claycomo
Craig
El Dorado Springs

MISSOURI(cont.)
Excelsior Springs
Gladstone
Golden
Gower
Grandview
Harrisonville
Independence
Jasper
Joplin
Kansas City Metro
King City
Lamar
Lee's Summit
Liberty
Maryville
Monett
Mound City
Mt. Vernon
Nevada
Noel
North Kansas City
Oregon
Parkville
Platte City
Plattewoods
Pleasanton
Raytown
Rich Hill
Rockport
St. Joseph
Sarcoxie
Savannah
Seligman
Seneca
Sheldon
Smithville
Stanberry
Tarkio
Urich

MISSOURI(cont.)
Warrensburg
Webb City

NEBRASKA
Alma
Araphoe
Auburn
Axtell
Ayr
Beatrice
Beaver City
Benkelman
Bertrand
Blue Hill
Cambridge
Chester
Clay Center
Cortland
Curtis
Deshler
Elwood
Fairbury
Falls City
Franklin
Geneva
Hastings
Hayes Center
Hebron
Holdrege
Humboldt
Indianola
Kearney
Maywood
McCook
Minden
Nelson
Oxford
Pawnee City
Red Cloud

NEBRASKA(cont)
Sterling
Stockville
Superior
Sutton
Table Rock
Tecumseh
Wilsonville
Wymore

OKLAHOMA
Afton
Alva
Bartlesville
Beaver
Blackwell
Boise City
Buffalo
Cherokee
Cleveland
Collinsville
Commerce
Dewey
Enid
Grainola
Grove
Guymon
Hooker
Laverne
Medford
Miami
Nowata
Pawnee
Ponca City
Vinita
Wakita
Waynoka
Woodward

2400. PROGRAM INTEGRITY Updated 02/16

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 MCOs 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 beneficiary. 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.

KMAP Audit Protocols
The KMAP Audit Protocols are available on the Provider page of the KMAP website under the ***Helpful Information*** heading.

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.

2400. Updated 03/13

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 KMAP:

- 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% 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 fee-for-service 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 03/16

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 beneficiary. 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 MCOs, 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.

Solicitation by Provider

KMAP does not allow any form of solicitation targeting physicians, mid-level practitioners, or beneficiaries for services or supplies.

Fraud and Abuse

Beneficiary

The DCF 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.

2400. Updated 07/11

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.

2400. Updated 07/11

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 03/13

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 long-term care facility 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 DCF office.

Complaints received in writing will be forwarded to:

DCF
Prevention and Protection Services
Docking State Office Building
915 SW Harrison
Topeka, KS 66612

The complainant should be given the toll-free hot line number of DCF, **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.

How to Report

Call DCF 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 DCF office.

Call **1-800-922-5330** regarding abuse, neglect or exploitation in a home setting, go in person, or write your local DCF office.

2700. DOCUMENTATION REQUIREMENTS Updated 10/15

Claim/Record Storage Requirements

K.S.A. 21-5931 – 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 for Fee-For-Service Medicaid Program

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 beneficiaries 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 beneficiaries, 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 beneficiaries 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 Fee-for-Service Provider Manual*.)

2700. Updated 12/15

- 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.
- Hospital charges incurred after the physician has discharged the patient from inpatient care.
- Hypnosis, biofeedback, or relaxation therapy.
- Infertility services (any tests, procedures, or drugs related to infertility services).
- 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 and team or therapy coordinators 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.

2700. Updated 07/11

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?

- 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 will 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 is acceptable for Medicaid:

- Meet all documentation and signature requirements contained in this 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 record all activity that occurs within the EHR system including user name and documentation of event description such as amendment, correction, or deletion – with date and time. The EHR system audit log must remain operational at all times and available upon request.

2700. Updated 10/15

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.

Electronic records, as with all forms of documentation, must be valid, accurate, complete, trustworthy, and timely. Tools available to increase clinician efficiency must be used in a manner which ensures documentation integrity. Examples include:

- Use of templates (also known as default features, self-populating fields, etc.) must be modified to contain data which is accurate and complete as it pertains to each individual visit while all irrelevant data is removed. For example, the automatic generation of common negative findings within a review of each body area or organ system may result in a higher level of service than actually provided, unless the provider documents any pertinent positive results and deletes the incorrect auto-generated entries. Automated insertion of data when not modified to be patient-specific and pertinent to the visit will result in recoupment of payment(s).
- Use of cloned documentation (also known as copy and paste, "make me the author" functionality, etc.) must contain data which is accurate and complete as it pertains to each individual visit with all irrelevant data removed. For example, the cloning of documentation from visit to visit or patient to patient (vital signs that never change, prostate exam on a female patient) may result in inaccurate information unless the provider deletes the incorrect cloned documentation. Cloned documentation not modified to be patient-specific and pertinent to the visit will result in recoupment of payment(s).

Refer to the Program Integrity: Electronic Health Records page on the CMS.gov website for additional assistance to ensure the proper use of EHR features and capabilities.

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance will 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 09/15

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.

  Developmental Therapy Services

  Medicaid covers developmental physical therapy, developmental occupational therapy, and developmental speech therapy services for children under 21 years of age. Individuals can receive developmental therapy services to treat autism spectrum disorders (ASDs), birth defects, and other developmental delays in any appropriate community setting from any qualified provider with PA and medical necessity documentation.

  Coverage will be available for the diagnosis and treatment of ASD. Diagnosis must be established using an appropriate assessment instrument and performed by an appropriately licensed medical provider. Services must be preapproved and may include developmental speech therapy, developmental occupational therapy, or developmental physical therapy as appropriate. An initial comprehensive assessment to establish a baseline must be completed. Periodic re-evaluations and assessments are required at least every six months and continuous improvement must be shown in order to qualify for continued treatment.

  The provision of services for all children with birth defects and developmental delays, which include ASDs, will be allowed by any qualified provider in any appropriate place of service. The services will include developmental physical therapy, developmental occupational therapy, and developmental speech/language pathology services as documented in a comprehensive treatment plan. A treatment plan means a submission by a provider or group of providers, signed by both the provider(s) and parent(s)/caregiver(s), that includes:

  - The type of therapy to be administered and methods of intervention
  - The goals: including specific problems or behaviors requiring treatment, frequency of services to be provided, frequency of parent or caregiver participation at therapy sessions, description of supervision, periodic measures for the therapy, and frequency at which goals will be reviewed and updated
  - Who will administer the therapy
  - The patient's current ability to perform the desired results of therapy

  Dependent on dates of service, an acceptable ICD-9 or ICD-10 diagnosis will be required on the treatment plan. For dates of service prior to October 1, 2015, the following diagnosis codes will not be accepted as a primary diagnosis:

  - 780.99: General symptoms
  - 783.40: Lack of expected normal physiologic development

  For dates of service on and after October 1, 2015, the following diagnosis codes will not be accepted as a primary diagnosis:

  - R62.50: Unspecified lack of expected normal physiological development in childhood
  - R62.59: Other lack of expected normal physiological development in childhood
  - R68.89: Other general symptoms and signs

  Note: These services require a PA be on file for payment regardless of what the KMAP website HCPCS Code Search page displays.
- ***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.

2710. Updated 08/15

- 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 05/17

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 with place of service (POS) 02 - Telemedicine 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 along with an E&M code that is appropriate for the service to Medicaid for determination of whether payment is due.

90785GT	90791GT	90792GT	90832GT	90833GT	90834GT	90836GT	90837GT
90838GT	90839GT	90840GT	90847GT	90863GT	92227GT	92228GT	96116GT
97802GT	97803GT	99201GT	99202GT	99203GT	99204GT	99205GT	99211GT
99212GT	99213GT	99214GT	99215GT	99221GT	99222GT	99223GT	99304GT
99305GT	99306GT	99366GT	99367GT	99368GT	G0406GT	G0407GT	G0408GT
G0425GT	G0426GT	G0427GT	G0508GT	G0509GT	H0001GT	H0004GT	H0005GT
H0006GT	H0007GT	H0032HAGT	H0038GT	H0038HQGT	Q3014GT	T1023GT	
T1030*****	T1031*****						

***Telehealth only**

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.

2800. HOSPICE Updated 07/16

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
An individual can elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

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 Fee-for-Service 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.

2800. **Updated 07/16**

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

Concurrent hospice care for children will be covered for the duration needed. An individual may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

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.

2910. IMMUNIZATION ADMINISTRATION Updated 12/16

Providers must bill the appropriate administration code in addition to the vaccine and toxoid code for each dose administered. Reimbursement of *CPT*® codes for vaccines covered under the Vaccines for Children (VFC) program will not be allowed for children 18 years of age and younger.

COVERAGE INDICATORS

ADLT Vaccine covered for adults (19 years of age and older)
VFC Vaccine covered by VFC (18 years of age and younger)

ADMINISTRATION CODES

90471	90472	90473	90474

VACCINE CODES

Coverage	Code		Coverage	Code
VFC	90698		VFC, ADLT	90662
VFC	90700		VFC, ADLT	90707
VFC	90702		VFC, ADLT	90710
VFC	90720		VFC	90733
VFC	90696		VFC, ADLT	90734
VFC	90723		VFC	90669
ADLT	90632		VFC, ADLT	90670
VFC	90633		VFC, ADLT	90732
VFC	90634		VFC, ADLT	90713
ADLT	90636		VFC	90680
ADLT	90740		VFC	90681
VFC	90743		VFC	90685
VFC	90744		VFC, ADLT	90686
ADLT	90746		VFC	90687
ADLT	90747		VFC, ADLT	90688
VFC	90748		VFC	90703
VFC	90644		VFC, ADLT	90714
VFC	90645		VFC, ADLT	90715
VFC	90646		VFC, ADLT	90716
VFC	90647		ADLT	90736
VFC	90648		VFC, ADLT	90672
VFC, ADLT	90649		ADLT	90739
VFC, ADLT	90650		VFC	Q2035
VFC, ADLT	90653		VFC	Q2036
VFC	90654		VFC	Q2037
VFC	90655		VFC	Q2038
VFC, ADLT	90656		VFC	Q2039
VFC	90657		VFC	90651
VFC, ADLT	90658		VFC	90674
VFC, ADLT	90660			

Note: Use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information is available on the public website.
- Information is available on the secure website under Pricing and Limitations.

For further assistance, contact the Customer Service at 1-800-933-6593.