



KANSAS MEDICAL ASSISTANCE PROGRAM
Provider Manual

HCBS
Frail Elderly

**PART II
HCBS FE PROVIDER MANUAL**

Section	BILLING INSTRUCTIONS	Page
7000	HCBS FE Billing Instructions	7-1
	Submission of Claim.....	7-1
7010	HCBS FE Specific Billing Information	7-2
	 BENEFITS AND LIMITATIONS	
8400	HCBS FE Benefits and Limitations.....	8-1
	HCBS FE Adult Day Care.....	8-1
	HCBS FE Assistive Technology	8-3
	HCBS FE Attendant Care Services	8-5
	HCBS FE Comprehensive Support.....	8-14
	HCBS FE Home Telehealth.....	8-17
	HCBS FE Medication Reminder	8-20
	HCBS FE Nursing Evaluation Visit	8-21
	HCBS FE Personal Emergency Response	8-23
	HCBS FE Sleep Cycle Support	8-25
	HCBS FE Wellness Monitoring	8-28
	Expected Service Outcomes	8-30

FORMS All forms pertaining to this provider manual can be found on the public website at <https://www.kmap-state-ks.us/Public/forms.asp> and on the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations. Sample forms may be used to document HCBS FE services. Use of these forms is not required, but they can be duplicated for your use.

INTRODUCTION TO THE HCBS FE PROGRAM Updated 03/12

The Home and Community Based Services for the Frail Elderly (HCBS FE) waiver program is designed to meet the needs of beneficiaries 65 years of age and older who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.

- Adult Day Care
- Assistive Technology
- Attendant Care Services
- Comprehensive Support
- Financial Management Services

Note: Refer to the *HCBS Financial Management Services Provider Manual* for criteria and information.

- Home Telehealth
- Medication Reminder
- Nursing Evaluation Visit
- Oral health services

Note: Refer to the *Dental Provider Manual* for criteria and information.

- Personal Emergency Response
- Sleep Cycle Support
- Wellness Monitoring

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

Money Follows the Person Program

Money Follows the Person (MFP) services are available to qualified beneficiaries. These services are specific to beneficiaries transitioning into the community from designated institutional settings. Refer to the *Money Follows the Person Provider Manual* for criteria and additional information.

Enrollment

All HCBS FE providers must enroll and receive a provider number for HCBS FE services. Contact the fiscal agent to enroll.

Miscellaneous Documentation

With the transition to an Electronic Verification and Monitoring (EV&M) system through KS AuthentiCare, recoupments are no longer identified solely based on the lack of meeting documentation requirements for dates of service from January 1 to April 30, 2012.

Notes in KS AuthentiCare

Providers are expected to use the “notes” field in the KS AuthentiCare web application every time adjustments are made (time in/out or activity codes, for example). At a minimum, the following information needs to be included in the note:

- The person requesting the adjustment
- Specifically what is being adjusted (clock in at 10:35 a.m. added, activity codes for bathing added and toileting removed, etc.)
- Reason for the adjustment (started shopping outside of home, forgot to clock in/out, etc.)
- If the adjustment was confirmed with the beneficiary

INTRODUCTION TO THE HCBS FE PROGRAM Updated 06/11

Signature Limitations for All FE Services

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

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

- Beneficiary's signature
- Beneficiary making a distinct mark representing his or her signature
- Beneficiary using his or her signature stamp
- Designated signatory

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

Beneficiaries who refuse to sign accurate time sheets when there is no legitimate reason should be advised that the direct support worker's time may not be paid or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned time sheets are a matter for the billing provider to address.

HIPAA Compliance

As a participant in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required during its review and investigation. The provider is required to provide access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

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

7000. HCBS FE BILLING INSTRUCTIONS Updated 03/12

Introduction to the CMS-1500 Claim Form

Providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services provided under KMAP. Any CMS-1500 claim not submitted on a red claim form will be returned to the provider. An example of the CMS-1500 claim form is:

- On the public website at <https://www.kmap-state-ks.us/Public/forms.asp>
- On the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp>

The Kansas Medicaid Management Information System (MMIS) will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to Section 1100 of the *General Introduction Provider Manual*.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the *General Billing Provider Manual*.

Submission of Claim

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

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

All claims for HCBS FE services, with the exception of oral health services, provided outside of licensed nursing, assisted living, residential health care, home plus, or boarding care facilities must be submitted through the EV&M system, KS Authenticare, web application.

7010. HCBS FE SPECIFIC BILLING INSTRUCTIONS Updated 11/12

ADULT DAY CARE

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Adult Day Care, half day

Enter procedure code S5101 in field 24D of the CMS-1500 claim form.

One unit equals one to five hours and is limited to one unit per day ~~no more than two units in a 24-hour period.~~

Adult Day Care, per diem

Enter procedure code S5102 in field 24D of the CMS-1500 claim form.

One unit equals more than five hours and is limited to one unit per day.

Only one Adult Day Care service (either S5101 or S5102) can be billed on the same day by the same provider.

ASSISTIVE TECHNOLOGY

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code T2029 in field 24D of the CMS-1500 claim form.

One unit equals one purchase.

ATTENDANT CARE SERVICES

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Provider-Directed Attendant Care

Level One- Enter procedure code S5130 in field 24D of the CMS-1500 claim form.

Level Two- Enter procedure code S5125 in field 24D of the CMS-1500 claim form.

Level Three - Enter procedure code with modifier S5125UA in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

Self-Directed Attendant Care

Enter procedure code with the modifier, S5125UD, in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

COMPREHENSIVE SUPPORT

Enter code 780.99 in field 21 of the CMS-1500 claim form.

Provider-Directed Comprehensive Support

Enter procedure code S5135 in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

Self-Directed Comprehensive Support

Enter procedure code with modifier, S5135UD, in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

7010. HCBS FE SPECIFIC BILLING INSTRUCTIONS Updated 08/11

HOME TELEHEALTH

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code S0317 in field 24D of the CMS-1500 claim form.

One unit equals one day.

Installation of Home Telehealth equipment and training – Enter procedure code S0315 in field 24D of the CMS-1500 claim form. **Installation is covered up to twice per calendar year.**

MEDICATION REMINDER

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code S5185 in field 24D of the CMS-1500 claim form.

One unit equals one month.

NURSING EVALUATION VISIT

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code T1001 in field 24D of the CMS-1500 claim form.

One unit equals one face-to-face visit.

PERSONAL EMERGENCY RESPONSE

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Rental of Personal Emergency Response - Enter procedure code S5161 in field 24D of the CMS-1500 claim form.

One unit equals one month.

Installation of Personal Emergency Response - Enter procedure code S5160 in field 24D of the CMS-1500 claim form.

Installation is covered up to twice per calendar year.

SLEEP CYCLE SUPPORT

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code T2025 in field 24D of the CMS-1500 claim form.

One unit equals six to twelve hours. Only one unit is allowed within a 24-hour period of time.

WELLNESS MONITORING

Enter diagnosis code 780.99 in field 21 of the CMS-1500 claim form.

Enter procedure code S5190 in field 24D of the CMS-1500 claim form.

One unit equals one face-to-face visit.

Note: Although for billing purposes the system POC is authorized on a monthly basis, the total hours for a beneficiary cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and the Notice of Action.

Client Obligation

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

7010. HCBS FE SPECIFIC BILLING INSTRUCTIONS Updated 06/11

Overlapping Dates of Service

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

Example

An electronic POC has two detail line items: the first line ends on the 15th of the month and the second line begins on the 16th with an increase of units. A claim with a line item for services dated the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC for one line on a claim. For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month will be accepted by the system and not deny because of a conflict in the dates of service. Services for multiple months should be separated out and each month submitted on a separate claim.

Same Day Service

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

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

8400. BENEFITS AND LIMITATIONS Updated 11/12

ADULT DAY CARE

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

This service includes:

- Basic nursing care as delegated or provided by a licensed nurse and as identified in the service plan
- Daily supervision/physical assistance with certain activities of daily living limited to eating, mobility, and may include transfer, bathing, and dressing as identified in the Customer Service Worksheet (CSW).

This service shall not duplicate other waiver services.

ADULT DAY CARE LIMITATIONS

- Service may not be provided in the beneficiary's own residence.
- Beneficiaries living in an assisted living facility, residential health care facility, or home plus facility are not eligible for this service.
- Service is limited to a maximum of two units of service per day, one or more days per week.
- A registered nurse (RN) must be available on-call as needed.
- Special dietary needs are not required but may be provided as negotiated on an individual basis between the beneficiary and the provider. No more than two meals per day may be provided.
- Transfer, bathing, toileting, and dressing are not required but may be provided as negotiated on an individual basis between the beneficiary and the provider as identified in the individual's POC and if the provider is capable of this scope of service.
- Therapies (physical, occupational, and speech) and transportation are not covered under this service but may be covered through regular Medicaid.

ADULT DAY CARE ENROLLMENT

Providers must be licensed by the Kansas Department on Aging (KDOA). Licensed entities include free-standing adult day care facilities, nursing facilities, assisted living facilities, residential health care facilities, and home plus facilities.

ADULT DAY CARE REIMBURSEMENT

Adult Day Care, half day

One unit equals one to five hours and is limited to one unit per day ~~no more than two units in a 24 hour period.~~

Maximum unit cost equals \$21.93.

Procedure code is S5101.

Adult Day Care, per diem

One unit equals more than five hours and is limited to one unit per day.

Maximum unit cost equals \$43.86.

Procedure code is S5102.

KANSAS MEDICAL ASSISTANCE PROGRAM
HCBS FE PROVIDER MANUAL
ADULT DAY CARE
BENEFITS & LIMITATIONS

8400. BENEFITS AND LIMITATIONS Updated 03/12

ADULT DAY CARE

ADULT DAY CARE REIMBURSEMENT (continued)

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery, provide consistency with other Medicaid services such as home health aide visits, and meet beneficiary preferences in providers and service delivery methods. The beneficiary will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the POC regardless of the length of time needed to deliver service.

ADULT DAY CARE DOCUMENTATION REQUIREMENTS

For a service provided within a licensed nursing, assisted living, residential health care, or home plus facility, written documentation is required for services provided and billed to KMAP. Documentation, at a minimum, must consist of an attendance record. This record must include the following:

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

This record must be generated and maintained during the time frame covered by the document. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Adult Day Care Log is on the KMAP public and secure websites and may be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use.

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

For a service provided in a licensed free-standing adult day care facility, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Adult Day Care)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the authorized staff member
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 06/11

ASSISTIVE TECHNOLOGY

Assistive technology (AT) consists of either one of the following:

- Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab bars, bath benches, toilet risers, and lift chairs
- Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings

ASSISTIVE TECHNOLOGY LIMITATIONS

- AT is limited to the beneficiary's assessed level of service need, as specified in the beneficiary's POC, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.
- All AT purchases require prior authorization from KDOA.
- This service must be cost-effective and appropriate to the beneficiary's needs.
- This service is limited to a lifetime maximum of \$7,500.
- AT funded by other waiver programs is calculated into the lifetime maximum.
- Payment is for the item or modification and does not include administrative costs.
- Repairs or maintenance are not allowed for home modifications or assistive items.
- Home modification includes only those adaptations that are necessary to accommodate the mobility of the beneficiary.
- Replacements and duplicate items shall not be covered for the first twelve months after the purchase date of the item.
- For home modifications to be authorized in a home not owned by the beneficiary, the owner/landlord must agree, in writing, to maintain the modifications for the time period in which the HCBS FE beneficiary resides there.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- External modifications (such as, porches, decks, and landings) will only be allowed to the extent required to complete the approved request.
- Home accessibility adaptations cannot be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- If Medicare covers an AT item but denies authorization, HCBS FE will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

ASSISTIVE TECHNOLOGY ENROLLMENT

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

ASSISTIVE TECHNOLOGY REIMBURSEMENT

One unit equals one purchase.

Procedure code is T2029.

**KANSAS MEDICAL ASSISTANCE PROGRAM
HCBS FE PROVIDER MANUAL
ASSISTIVE TECHNOLOGY
BENEFITS & LIMITATIONS**

8400. BENEFITS AND LIMITATIONS Updated 06/11

ASSISTIVE TECHNOLOGY

ASSISTIVE TECHNOLOGY DOCUMENTATION REQUIREMENTS

Written documentation is required for services provided and billed to KMAP. Documentation must include the following:

- The provider must maintain a copy of the receipt identifying that the service was provided. The receipt must include:
 - Name of the provider
 - Identification of item or technology being provided
 - Date of service (MM/DD/YY)
 - Amount of purchase
 - Beneficiary's name (first and last) and signature
- Documentation must be generated at the time of purchase. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Assistive Technology Receipt is on the KMAP public and secure websites and can be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 12/11

ATTENDANT CARE SERVICES

There are two methods of providing attendant care services, provider-directed and self-directed. Beneficiaries are given the option to self-direct their attendant care services. A combination of service providers and types of attendant care, either provider-directed and/or self-directed, may be used to meet the approved POC.

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

Attendant Care Services provide supervision and/or physical assistance with instrumental activities of daily living (IADLs) and activities of daily living (ADLs) for beneficiaries who are unable to perform one or more activities independently (K.S.A. 65-6201). Attendant Care Services may be provided in the beneficiary’s choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

There are three levels of provider-directed attendant care services, which are referred to as Level I, Level II, and Level III. A combination of Level I (Services A & B) and Level II (Services C & D) can be used in the development of the POC. If a combination of Level I and Level II services are included in the POC, the Level II rate shall be paid if both levels of care are provided by the same provider. Level III will be used in the development of the POC for those beneficiaries residing in adult care homes. For boarding care homes, the tasks authorized on the POC must fall within the licensing regulations.

Level I	
Service A	Service B
Home management of IADLs <ul style="list-style-type: none"> • Shopping • House cleaning • Meal preparation • Laundry 	IADLs <ul style="list-style-type: none"> • Medication set up, cueing, and reminding (supervision only)
	ADLs-direct support worker supervises the beneficiary <ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services

Enrollment

For Service A only

- Nonmedical resident care facilities licensed by the Kansas Department of Social and Rehabilitation Services (SRS)
- Entities not licensed by SRS, KDOA, or the Kansas Department of Health and Environment (KDHE) must provide the following:
 - A certified copy of its Articles of Incorporation or Articles of Organization

Note: If a corporation or limited liability company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.
 - Written proof of liability insurance or a surety bond

8400. BENEFITS AND LIMITATIONS Updated 12/11

ATTENDANT CARE SERVICES

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

Level I

For Services A or B

- County health departments
- The following entities licensed by KDHE:
 - Medicare-certified home health agencies
 - State-licensed home health agencies
- The following entity licensed by KDOA:
 - Boarding care homes

Reimbursement

One unit equals fifteen minutes.

Maximum unit cost for Level I A or B equals \$3.38.

Procedure code is S5130.

Level II

An initial RN evaluation visit is necessary.

Service C	Service D
ADLs-physical assistance or total support <ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services 	Health maintenance activities <ul style="list-style-type: none"> • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
	A direct support worker who is a certified home health aide or a certified nurse aide must not perform any health maintenance activities without delegation by a licensed nurse.
	A certified home health aide or certified nurse aide must not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.

8400. BENEFITS AND LIMITATIONS Updated 12/11

ATTENDANT CARE SERVICES

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

Level III

An initial RN evaluation visit is necessary.

IADLs	ADLs – Supervision, physical assistance, or total support	
<ul style="list-style-type: none"> • Shopping • House cleaning • Meal preparation • Laundry • Medication set up, cueing or reminding, and treatments 	<ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting 	<ul style="list-style-type: none"> • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services
HEALTH MAINTENANCE ACTIVITIES		
<ul style="list-style-type: none"> • Monitoring vital signs • Ostomy care • Catheter care • Enteral nutrition 	<ul style="list-style-type: none"> • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance • Supervision and/or training of nursing procedures 	

An attendant who is a certified home health aide or a certified nurse aide must not perform any health maintenance activities without delegation by a licensed nurse.

A certified home health aide or certified nurse aide must not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.

Enrollment for Level II Services C or D

- County health departments
- The following entities licensed by KDHE
 - Medicare-certified home health agencies
 - State-licensed home health agencies

Reimbursement

- One unit equals fifteen minutes.
- Maximum unit cost for Level II C or D equals \$3.73.
- Procedure code is S5125.

Enrollment for Level III Services

- The following entities licensed by KDOA:
 - Home plus facilities
 - Assisted living facilities
 - Residential health care facilities

Reimbursement

- One unit equals fifteen minutes.
- Maximum unit cost for Level III equals \$4.12.
- Procedure code is S5125UA.

8400. BENEFITS AND LIMITATIONS Updated 03/12

ATTENDANT CARE SERVICES

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

Medication Administration/Assistance in Licensed Facilities

(K.A.R. 26-41-205 and K.A.R. 26-42-205)

- Any resident can self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
- Any resident who self-administers medication can select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.
- If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.

Medication Administration Assistance in a Private Residence (K.A.R. 28-51-108)

- A KDHE-licensed or Medicare-certified home health agency can provide nursing delegation to aides with sufficient training.
- The nurse delegation and training must be specific to the particular beneficiary and his or her health needs.
- The qualified nurse retains overall responsibility.

ATTENDANT CARE SERVICES DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

In Home Care

For a service provided outside of a licensed adult care home, documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Attendant Care Services, Level I or II)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the direct support worker providing the tasks
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours
- Identification of activities performed during each visit

For a postpayment review, reimbursement will be recouped if documentation is not complete.

8400. BENEFITS AND LIMITATIONS Updated 03/12

ATTENDANT CARE SERVICES

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

In Home Care

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Attendant Care Services, Level I or II)
- Beneficiary's name (first and last) and signature on each page of documentation
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Note: For beneficiaries who have been notified by a targeted case manager to receive services (Attendant Care Services, Level I or II) under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

**Assisted Living Facilities, Residential Health Care Facilities,
Home Plus Facilities, and Boarding Care Homes**

Written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Attendant Care Services, Level III)
- Beneficiary's name (first and last) and signature must be on each page of documentation
- Direct support worker's name and signature must be on each page of documentation
- Date of service (MM/DD/YY)
- Time spent daily for services rendered
- Identify activities performed during each contact
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of the billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Limitations (Levels I, II, and III)

- Direct support workers must be 18 years of age or older.
- Covered ADL and IADL services are limited as defined within the CSW and approved POC.
- Attendant care is limited to a maximum of 48 units (12 hours) per day of any combination of provider-directed Level I, provider-directed Level II, and self-directed.
- Attendant care is limited to a maximum of 48 units (12 hours) per day for provider-directed Level III.

8400. BENEFITS AND LIMITATIONS Updated 03/12

ATTENDANT CARE SERVICES

PROVIDER-DIRECTED ATTENDANT CARE SERVICES

Limitations (Levels I, II, and III) (continued)

- Transportation is not covered with this service, but, if medically necessary, it may be covered through regular Medicaid.
- A beneficiary’s spouse, guardian, conservator, person authorized as an activated durable power of attorney (DPOA) for health care decisions, or an individual acting on behalf of a beneficiary shall not be paid to provide attendant care for the beneficiary. The only exception to this policy will be a relative who is an employee of an assisted living facility, residential health care facility, or home plus facility in which the beneficiary resides and the relative’s relationship is within the second degree of the beneficiary. (See K.A.R. 26-41-101 and K.A.R. 26-42-101 for regulatory requirements.)
- The service will not be paid while the beneficiary is hospitalized, in a nursing home, or in any other situation where the beneficiary is not available to receive the service.
- More than one direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and the case log by the case manager, for example, two-man lift for safety issues.
- Direct support workers are not allowed to work and be paid for multiple HCBS beneficiaries at the same date and time.

SELF-DIRECTED ATTENDANT CARE SERVICES

Attendant Care Services provide supervision and/or physical assistance with instrumental activities of daily living (IADLs) and activities of daily living (ADLs) for beneficiaries who are unable to perform one or more activities independently (K.S.A. 65-6201). Attendant Care Services may be provided in the beneficiary’s choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

IADLs	ADLs	
<ul style="list-style-type: none"> • Shopping • House cleaning • Meal preparation • Laundry • Medication set up, cueing or reminding, and treatments 	<ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting 	<ul style="list-style-type: none"> • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services
HEALTH MAINTENANCE ACTIVITIES		
<ul style="list-style-type: none"> • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition 	<ul style="list-style-type: none"> • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance 	

8400. BENEFITS AND LIMITATIONS Updated 12/11

ATTENDANT CARE SERVICES

SELF-DIRECTED ATTENDANT CARE SERVICES

Beneficiaries or their representatives are given the option to self-direct their attendant care services. The beneficiary's representative may be an individual acting on behalf of the beneficiary, an activated DPOA for health care decisions, or a guardian and/or conservator. If the beneficiary or representative chooses to self-direct attendant care, he or she is responsible for making choices about attendant care services including referring for hire, supervising, and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results. Self-directed attendant care is subject to the same quality assurance standards as other attendant care providers including, but not limited to, completion of the tasks identified on the Customer Service Worksheet.

Refer to the *HCBS Financial Management Service Provider Manual* for additional information on responsibilities.

According to K.S.A. 65-1124(I), a beneficiary who chooses to self-direct care is not required to have attendant care supervised by a nurse. Furthermore, K.S.A. 65-6201(d) states that health maintenance activities can be provided “. . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.” Health maintenance activities and medication set up must be authorized, in writing, by a physician or licensed professional nurse.

Enrollment

To enroll, providers must meet the provider requirements for Financial Management Service (FMS). Direct support workers must be referred to the enrolled FMS provider of the beneficiary's choice for completion of required human resources and payroll documentation.

Documentation Requirements

Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

Documentation must be collected by using the EV&M system, KS Authenticare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Self-Directed Attendant Care Services)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the direct support worker providing the tasks
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit

For a postpayment review, reimbursement will be recouped if documentation is not complete.

8400. BENEFITS AND LIMITATIONS Updated 03/12

ATTENDANT CARE SERVICES

SELF-DIRECTED ATTENDANT CARE SERVICES

Documentation Requirements (continued)

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Self-Directed Attendant Care Services)
- Beneficiary's name (first and last) and signature on each page of documentation
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

Reimbursement

One unit equals 15 minutes.

Maximum unit cost equals \$2.71.

Procedure code with modifier is S5125UD.

Limitations

- Direct support workers must be 18 years of age or older.
- A beneficiary who has a guardian and/or conservator cannot choose to self-direct his or her attendant care; however, a guardian and/or conservator can make that choice on the ward's behalf.
- A guardian, conservator, person authorized as an activated DPOA for health care decisions, or individual acting on behalf of the beneficiary cannot choose himself or herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the beneficiary's paid direct support worker after the next annual review or a significant change in the beneficiary's needs occurs prompting a reassessment.

EXCEPTION to this limitation: Beneficiaries who were active on any HCBS waiver prior to July 1, 2000, and have had the same representative continually directing their care during that time, are exempt from this limitation. The targeted case manager shall complete a home visit at least every three months to ensure that the selected direct support worker is performing the necessary services.

8400. BENEFITS AND LIMITATIONS Updated 03/12

ATTENDANT CARE SERVICES

SELF-DIRECTED ATTENDANT CARE SERVICES

Limitations (continued)

- While a family member may be paid to provide attendant care, a beneficiary's spouse will not be paid to provide attendant care services unless one of the following criteria from K.A.R. 30-5-307 are met and prior approval received from the KDOA TCM program manager:
 - Three HCBS provider agencies furnish written documentation that the beneficiary's residence is so remote or rural that HCBS services are otherwise completely unavailable.
 - Two health care professionals, including the attending physician, furnish written documentation that the beneficiary's health, safety, or social well-being would be jeopardized. (Documentation must contain how or in what way the beneficiary's health, well-being, safety, or social well-being would be jeopardized.)
 - The attending physician furnishes written documentation that, due to the advancement of chronic disease, the beneficiary's means of communication can be understood only by the spouse.
 - Three HCBS providers furnish written documentation that delivery of HCBS services to the beneficiary poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.
- The targeted case manager and the beneficiary or his or her representative will use discretion in determining if the selected direct support worker can perform the needed services.
- Covered ADL and IADL services are limited as defined within the CSW and approved POC.
- Attendant care services are limited to a maximum of 48 units (12 hours) per day of any combination of provider-directed Level I, provider-directed Level II and self-directed.
- Transportation is not covered with this service, but, if medically necessary, it may be covered through regular Medicaid.
- This service will not be paid while the beneficiary is hospitalized, in a nursing home, or in any other situation where the beneficiary is not available to receive the service.
- More than one direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and case log by the case manager, such as two-man lift for safety issues.
- Direct support workers are not allowed to work and be paid for multiple HCBS beneficiaries at the same date and time.
- A beneficiary residing in an assisted living facility (ALF), residential health care facility (RHCF), home plus facility, or boarding care home has chosen that provider as his or her selected caregiver. These housing choices supersede the self-directed care choice.

8400. BENEFITS AND LIMITATIONS Updated 06/11

COMPREHENSIVE SUPPORT

Comprehensive Support is one-on-one, nonmedical assistance, observation, and supervision provided for a cognitively impaired adult to meet his or her health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care: the primary focus is supportive supervision.

The support worker is present to supervise the beneficiary and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example, reading mail, books, and magazines or writing letters) may also be provided.

Comprehensive Support may be provided in the beneficiary's choice of housing, including temporary arrangements.

This service shall not duplicate other waiver services.

There are two methods of providing Comprehensive Support, provider-directed and self-directed. Beneficiaries are given the option to self-direct their comprehensive support. A combination of service providers, either provider-directed and/or self-directed, can be used to meet the approved POC.

The beneficiary's representative is given the option to self-direct the beneficiary's Comprehensive Support. He or she may be an individual acting on behalf of the beneficiary, a person authorized as an activated durable power of attorney (DPOA) for health care decisions, a guardian, or a conservator. If the representative chooses to self-direct comprehensive support, he or she is responsible for making choices about Comprehensive Support, including referring for hire, supervising and terminating the employment of support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

Refer to the *HCBS Financial Management Service Provider Manual* for additional information on responsibilities.

COMPREHENSIVE SUPPORT LIMITATIONS

- Comprehensive Support is limited to the beneficiary's assessed level of service need, as specified in the beneficiary's POC, not to exceed 12 hours per 24-hour time period, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Support workers must be 18 years of age.
- Comprehensive Support is limited to a maximum of 48 units (12 hours) a day to occur during the beneficiary's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours a day.
- A beneficiary who has a guardian and/or conservator cannot choose to self-direct his or her Comprehensive Support; however, a guardian and/or conservator can make that choice on the beneficiary's behalf.
- Under no circumstances shall a beneficiary's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a beneficiary be paid to provide Comprehensive Support for the beneficiary.

KANSAS MEDICAL ASSISTANCE PROGRAM
HCBS FE PROVIDER MANUAL
COMPREHENSIVE SUPPORT
BENEFITS & LIMITATIONS

8400. BENEFITS AND LIMITATIONS Updated 09/11

COMPREHENSIVE SUPPORT

- For a beneficiary self-directing, the targeted case manager and the beneficiary or his or her representative will use discretion in determining if the selected support worker can perform the needed services.
- Beneficiaries residing in an assisted living facility, residential health care facility, home plus facility, or boarding care home must have this service provided by a licensed home health agency and are not eligible to self-direct this service.
- An individual providing Comprehensive Support must have a permanent residence separate and apart from the beneficiary.
- This service is limited to those beneficiaries who live alone or do not have a regular caretaker for extended periods of time.
- Comprehensive Support cannot be provided at the same time as the HCBS FE Attendant Care Services or HCBS FE Sleep Cycle Support.
- This service will not be paid while the beneficiary is hospitalized, in a nursing home, or in any other location where he or she is unable to receive the service.
- Support workers are not allowed to work and be paid for multiple HCBS beneficiaries at the same date and time.

PROVIDER-DIRECTED COMPREHENSIVE SUPPORT ENROLLMENT

- Medicare-certified or KDHE-licensed home health agencies
 - CILs
 - County health departments
 - Entities not licensed by the SRS, KDOA, or KDHE
- Note:* These entities must provide the following documentation:
- A certified copy of its Articles of Incorporation or Articles of Organization. If a corporation or limited liability company is organized in a jurisdiction outside the State of Kansas, the entity must provide written proof that it is authorized to do business in the State of Kansas.
 - Written proof of liability insurance or surety bond.

SELF-DIRECTED COMPREHENSIVE SUPPORT ENROLLMENT

To enroll, providers must meet the provider requirements for FMS. Direct support workers must be referred to the enrolled FMS provider of the beneficiary's choice for completion of required human resources and payroll documentation.

COMPREHENSIVE SUPPORT REIMBURSEMENT

One unit equals 15 minutes.

Maximum unit cost equals \$3.38 per unit of provider-directed service.
Procedure code is S5135.

Maximum unit cost equals \$2.71 per unit of self-directed service.
Procedure code with modifier is S5135UD.

8400. BENEFITS AND LIMITATIONS Updated 03/12

COMPREHENSIVE SUPPORT

COMPREHENSIVE SUPPORT DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable.

Documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Comprehensive Support)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the direct support worker providing the tasks
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Comprehensive Support)
- Initials of both beneficiary and support worker for each visit if using a log which covers more than one day
- Beneficiary's name (first and last) and signature, on each page of documentation
- Support worker's name and signature, on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours
- Time must be totaled by actual minutes and hours worked.

Note: Billing staff may round the total to the nearest quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment. Sample forms are on the KMAP public and secure websites. They may be used to document HCBS FE services. Use of these specific forms is not required, but they may be duplicated for your use.

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 08/11

HOME TELEHEALTH

Home Telehealth is a remote monitoring system provided to a beneficiary with one or more qualifying chronic diseases. It enables the beneficiary to effectively manage the disease(s) and recognize early signs of any problematic issues so intervention can occur before his or her health declines. The provision of Home Telehealth involves beneficiary education specific to the disease(s), counseling, and nursing supervision.

Home Telehealth automates disease management activities and engages beneficiaries with personalized daily interactions and education to build and expand their self-management behaviors. After gauging the beneficiary's progress, the service enables providers to encourage behavioral changes through user-friendly technology. This helps the beneficiary meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

The provider can access the telehealth system to review:

- Beneficiary's baseline (defined by the beneficiary's physician at enrollment)
- Survey responses
- Vital sign measurements

A licensed nurse monitors the health status of each beneficiary and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.

A beneficiary can qualify for this service if he or she needs disease management consultation and education. In addition, the beneficiary must have had two or more hospitalizations, including emergency room visits, within the previous year related to one or more diseases or be using MFP to move from a nursing facility back into the community. The provider must train the beneficiary and caregiver in how to use the equipment. The provider must also ensure ongoing beneficiary education specific to the disease(s), counseling, and nursing supervision. Beneficiary education can include topics such as learning symptoms to report, the disease process, risk factors, and other relevant aspects related to the disease.

Note: Beneficiaries living in an assisted living facility, residential health care facility, or home plus facility are not eligible for this service.

Home Telehealth is not a duplication of Medicare telehealth services. While the Kansas legislature calls this service home telehealth, the actual service follows the Centers for Medicare and Medicaid Services (CMS) telemonitoring definition which Medicare does not cover. HCBS FE Home Telehealth is a daily monitoring of the beneficiary's vital sign measurements from his or her home setting to prevent a crisis episode. Medicare telehealth includes specific planned contacts for professional consultations, office visits, and office psychiatry services, usually through video contact.

During KDOA's plan of care approval process, KDOA will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits. If a prior authorization is identified, HCBS FE Home Telehealth will be denied.

8400. BENEFITS AND LIMITATIONS Updated 08/11

HOME TELEHEALTH

HOME TELEHEALTH LIMITATIONS

- RN or licensed practical nurse (LPN) with RN supervision to set up, supervise, and provide beneficiary counseling
- Beneficiary landline or wireless connection
- Installation within 10 working days of approval
- Maximum of two installations per calendar year
- Monthly status reports to the physician and case manager
- Minimum monthly beneficiary contact to reinforce positive self-management behaviors

Note: If beneficiary fails to perform daily monitoring for seven consecutive days, the case manager must be notified to determine if continuation of the service is appropriate.

HOME TELEHEALTH ENROLLMENT

Providers can include home health agencies or county health departments with system equipment capable of monitoring beneficiary vital signs daily. This includes, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. Also, the provider must have the capability to ask the beneficiary questions which are tailored to his or her diagnosis.

The provider and equipment must have needed language options such as English, Spanish, Russian, and Vietnamese.

HOME TELEHEALTH REIMBURSEMENT

One unit equals one day of service.

Unit cost equals \$6.00.

Procedure code is S0317.

Install/Training: One unit equals one installation (maximum of two installations per calendar year).

Maximum cost equals \$70.00.

Procedure code is S0315.

HOME TELEHEALTH DOCUMENTATION REQUIREMENTS

- Medicaid requires written documentation of services provided and billed to KMAP. Documentation, at a minimum, must include the following:
 - Identification of the waiver service being provided
 - Beneficiary's name (first and last)
 - Nurse's name and signature with credentials
 - Date of service (MM/DD/YY)
 - Clinical measurements, as needed, based on the beneficiary's presentation
 - Review of systems, as needed, based on the beneficiary's presentation
 - Additional observations, interventions, and teaching issues
- Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 08/11

HOME TELEHEALTH

Electronic Documentation

Documentation must include the following:

- Waiver service being provided (Home Telehealth)
- Beneficiary receiving the service
- Nurse providing the service(s)
- Date of service (MM/DD/YY)
- Clinical measurements, as needed, based on the beneficiary's presentation
- Review of systems, as needed, based on the beneficiary's presentation
- Additional observations, interventions, and teaching issues
- Beneficiary's signature authorizing the use of the electronic documentation system at the start of service delivery

Note: Electronic documentation of service delivery is allowed, when meeting both documentation standards and signature standards as outlined above.

8400. BENEFITS AND LIMITATIONS Updated 08/11

MEDICATION REMINDER

A medication reminder service provides a scheduled reminder to a beneficiary when it's time for him or her to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the provider's system.

This service does not duplicate other waiver services.

MEDICATION REMINDER LIMITATIONS

- Maintenance of rental equipment is the provider's responsibility.
- Repair/replacement of rental equipment is not covered.
- Rental, but not purchase, of equipment is covered.
- This service is limited to those beneficiaries who live alone, or who are alone a significant portion of the day and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
- These systems may be maintained on a monthly rental basis even if a beneficiary is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed two months following the admission month in accordance with public assistance policy.
- This service is available in the beneficiary's place of residence, excluding adult care homes.

MEDICATION REMINDER ENROLLMENT

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

MEDICATION REMINDER REIMBURSEMENT

One unit equals one month.

Maximum unit cost equals \$15.91.

Procedure code is S5185.

8400. BENEFITS AND LIMITATIONS Updated 08/11

NURSING EVALUATION VISIT

Nursing Evaluation Visit is different from the initial assessment that is used to develop the POC. A nursing evaluation visit is a service provided only to beneficiaries that receive Level II Attendant Care Services through a home health agency, assisted living facility, residential health care facility, or other licensed entity. Nursing evaluation visits are conducted by a RN employed by the provider of Level II Attendant Care Services. During the nursing evaluation visit, the RN determines which direct support worker may best meet the needs of the beneficiary and any special instructions/requests of the beneficiary regarding delivery of services.

This service includes an initial face-to-face evaluation visit by an RN, one time, per beneficiary, per provider.

NURSING EVALUATION VISIT LIMITATIONS

- Nursing Evaluation Visit will need to be completed for a beneficiary who needs provider-directed Attendant Care Services Level II.
- If a beneficiary chooses a home health agency that has provided nursing services to the beneficiary in the past and the agency is already familiar with the beneficiary's health status, a nursing evaluation visit is not required.
- This service must be provided by an RN employed, or a self-employed RN contracted, by the Attendant Care Level II provider.
- A nursing evaluation visit is not conducted when a beneficiary chooses to self-direct Attendant Care Services (see the Attendant Care Scope of Services Statement).
- The RN is responsible for submitting a written report to the targeted case manager within two weeks of the visit. This report will include any observations or recommendations the nurse may have relative to the beneficiary which were identified during the nursing evaluation visit.

NURSING EVALUATION VISIT ENROLLMENT

- County health departments
- Self-employed RNs licensed in Kansas
- The following entities licensed by KDHE:
 - Medicare-certified home health agencies
 - State-licensed home health agencies
- The following entities licensed by the KDOA:
 - Home plus facilities
 - Assisted living facilities
 - Residential health care facilities

NURSING EVALUATION VISIT REIMBURSEMENT

One unit equals one face-to-face visit.

Maximum unit cost equals \$39.37.

Procedure code equals T1001.

8400. BENEFITS AND LIMITATIONS Updated 03/12

NURSING EVALUATION VISIT

NURSING EVALUATION VISIT DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. The nurse must provide the targeted case manager with a written summary of the visit within two weeks of the visit. The written summary must, at a minimum, include the following:

- Identification of the waiver service being provided
- Beneficiary's name (first and last) and signature
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Observations, interventions, teaching issues or instructions regarding delivery of services, etc.

For a service provided outside of a licensed adult care home, documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Nurse Evaluation Visit)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Nurse Evaluation Visit)
- Beneficiary's name (first and last) and signature
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Documentation must be generated at the time of the visit. Generating documentation after-the-fact is unacceptable. A sample of the HCBS FE Nursing Evaluation form is on the public and secure websites. It can be used to document HCBS FE services. Use of this specific form is not required, but it can be duplicated for your use.

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

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 08/11

PERSONAL EMERGENCY RESPONSE

Diagnosis alone does not determine need for this service. The targeted case manager authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal emergency response units are electronic devices and have portable buttons worn by the beneficiary. These units provide 24-hour-a-day on-call support to the beneficiary having a medical or emergency need that could become critical at anytime.

Examples include:

- Potential for injury
- Cardiovascular condition
- Diabetes
- Convulsive disorders
- Neurological disorders
- Respiratory disorders

PERSONAL EMERGENCY RESPONSE LIMITATIONS

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of rental equipment is not covered.
- Rental, but not purchase, of this service is covered.
- Call lights do not meet this definition.
- This service is limited to those beneficiaries who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
- Once installed, these systems may be maintained on a monthly rental basis even if the beneficiary is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
- Installation for each beneficiary is limited to twice per calendar year.

PERSONAL EMERGENCY RESPONSE ENROLLMENT

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

PERSONAL EMERGENCY RESPONSE REIMBURSEMENT

Rental: **One unit equals one month.**
Maximum unit cost equals \$26.52.
Procedure code is S5161.

Install: **One unit equals one installation (maximum of two installations per calendar year).**
Maximum unit cost equals \$56.25.
Procedure code is S5160.

8400. BENEFITS AND LIMITATIONS Updated 03/12

PERSONAL EMERGENCY RESPONSE

PERSONAL EMERGENCY RESPONSE DOCUMENTATION REQUIRMENTS

For the installation service provided outside of a licensed adult care home, documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Personal Emergency Response Installation)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the installer
- Date of service (MM/DD/YY)
- Start time for the installation, include AM/PM or use 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For an installation service provided outside of a licensed adult care home and for those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Personal Emergency Response Installation)
- Beneficiary's name (first and last) and signature
- Identification of the installer and signature
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For the monthly rental service, written documentation is not required.

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 08/11

SLEEP CYCLE SUPPORT

This service provides non-nursing physical assistance and/or supervision during the beneficiary's normal sleeping hours in the beneficiary's place of residence, excluding adult care homes. This service includes physical assistance or supervision with toileting, transferring and mobility, and prompting and reminding of medication. This service shall not duplicate other waiver services.

The direct support worker can sleep but must awaken as needed to provide assistance as identified in the beneficiary's service plan. The direct support worker must provide the beneficiary a mechanism to gain his or her attention or awaken him or her at any time. The direct support worker must be ready to call a physician, hospital, or other medical personnel should an emergency arise. The direct support worker must submit a report to the targeted case manager within the first business day following any emergency response provided to the beneficiary.

Sleep Cycle Support is a self-directed service. The beneficiary or representative is responsible for making choices about Sleep Cycle Support, including referring for hire, supervising, and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

Refer to the *HCBS Financial Management Service Provider Manual* for additional information on responsibilities.

SLEEP CYCLE SUPPORT LIMITATIONS

- Sleep Cycle Support is limited to the beneficiary's assessed level of service need, as specified in the beneficiary's POC, not to exceed 12 hours per 24-hour time period, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Direct support workers must be 18 years of age or older.
- Period of service must be at least six hours in length but cannot exceed a 12-hour period of time.
- Only one unit is allowed within a 24-hour period of time.
- Sleep Cycle Support in combination with other HCBS FE waiver services cannot exceed 24 hours per day.
- Under no circumstances shall a beneficiary's spouse, guardian, conservator, person authorized as an activated durable power of attorney (DPOA) for health care decisions, or an individual acting on behalf of a beneficiary be paid to provide Sleep Cycle Support for the beneficiary.
- Beneficiaries residing in an assisted living facility, residential health care facility, home plus facility, or boarding care home are not eligible for this service.
- The direct support worker must have a permanent residence separate and apart from the beneficiary.
- The targeted case manager and the beneficiary or his or her representative will use discretion in determining if the selected direct support worker can perform the needed services.
- This service shall not be paid while the beneficiary is hospitalized, in a nursing home, or in any other situation where he or she is unavailable to receive the service.
- Direct support workers are not allowed to work and be paid for multiple HCBS beneficiaries at the same date and time.

8400. BENEFITS AND LIMITATIONS Updated 03/12

SLEEP CYCLE SUPPORT

SLEEP CYCLE SUPPORT ENROLLMENT

To enroll, providers must meet the provider requirements for FMS. Direct support workers must be referred to the enrolled FMS provider of the beneficiary's choice for completion of required human resources and payroll documentation.

SLEEP CYCLE SUPPORT REIMBURSEMENT

One unit equals six to twelve hours.

Maximum unit cost equals \$22.44.

Procedure code is T2025.

Only one unit is allowed within a 24-hour period of time.

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery, to provide consistency with other Medicaid services such as home health aide visits, and to meet beneficiary preferences in providers and service delivery methods. Beneficiary health and safety and program cost effectiveness will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the plan regardless of the length of time needed to deliver the service.

SLEEP CYCLE SUPPORT DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

Documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Sleep Cycle Support)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the direct support worker
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Sleep Cycle Support)
- Beneficiary's name (first and last) and signature on each page of documentation
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

8400. BENEFITS AND LIMITATIONS Updated 03/12

SLEEP CYCLE SUPPORT

SLEEP CYCLE SUPPORT DOCUMENTATION REQUIREMENTS (continued)

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 08/11

WELLNESS MONITORING

This service provides a wellness monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a beneficiary's health concerns that have been identified by the targeted case manager. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the beneficiary during the visits are then brought to the attention of the targeted case manager and the physician as needed. A written report must be sent to the targeted case manager documenting the beneficiary's status within two weeks of the nurse visit.

This service includes:

- Nursing diagnosis
- Nursing treatment
- Counseling and health teaching
- Administration/supervision of nursing process
- Teaching of the nursing process
- Execution of the medical regimen

This service shall not duplicate other waiver services.

WELLNESS MONITORING LIMITATIONS

- Wellness monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the targeted case manager.
- Wellness monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. This report will be sent to the targeted case manager regarding the findings and recommendation of the licensed nurse.
- When an LPN performs this service, the provider must ensure that the requirements of the Nurse Practice Act are met.

WELLNESS MONITORING ENROLLMENT

- County health departments
- The following entities licensed by KDHE:
 - Medicare-certified home health agencies
 - State-licensed home health agencies
- The following entities licensed by KDOA:
 - Home plus facilities
 - Assisted living facilities
 - Residential health care facilities
- Self-employed RNs licensed in Kansas

WELLNESS MONITORING REIMBURSEMENT

One unit equals one face-to-face visit.

Maximum unit cost equals \$39.37.

Procedure code is S5190.

8400. BENEFITS AND LIMITATIONS Updated 03/12

WELLNESS MONITORING

WELLNESS MONITORING DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. The nurse must provide the targeted case manager with a written summary of the visit within two weeks of the visit. The written summary must, at a minimum, include the following:

- Identification of the waiver service being provided (Wellness Monitoring)
- Beneficiary's name (first and last) and signature
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Clinical measurements, as needed, based on the beneficiary's presentation
- Review of systems, as needed, based on the beneficiary's presentation
- Additional observations, interventions, teaching issues, etc.

For a service provided outside of a licensed adult care home, documentation must be collected by using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Wellness Monitoring)
- Identification of the beneficiary receiving the service (first and last name)
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For those limited instances where the beneficiary does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Wellness Monitoring)
- Beneficiary's name (first and last) and signature
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Documentation must be generated at the time of the visit. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Wellness Monitoring Log is on the public and secure websites. It may be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

Note: For beneficiaries who have been notified by a targeted case manager to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, KS AuthentiCare. Claims for services previously rendered must be manually entered into KS AuthentiCare to be confirmed and processed for payment.

**Expected Service Outcomes for Individuals or
Agencies Providing HCBS FE Services**

Updated 08/11

1. Services are provided according to the POC and in a quality manner and as authorized on the Notice of Action.
2. Coordinate provision of services in a cost-effective and quality manner.
3. Maintain beneficiary's independence and health, where possible, and in a safe and dignified manner.
4. Communicate beneficiary concerns/needs and changes in health status to the targeted case manager or independent living counselor within 48 hours, including any ongoing reporting as required by the Medicaid program.
5. Any failure or inability to provide services as scheduled in accordance with the POC must be reported immediately, but not to exceed 48 hours, to the targeted case manager or the independent living counselor.