KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

HCBS MR/DD Supportive Home Care
# PART II
## HCBS MR/DD SUPPORTIVE HOME CARE PROVIDER MANUAL

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## BENEFITS AND LIMITATIONS

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## FORMS

CMS-1500
The Home and Community Based Services (HCBS) Mental Retardation/Developmental Disabilities (MR/DD) program is designed to meet the needs of individuals who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those individuals with the desire to live outside of an institution. It is the beneficiary’s choice to participate in the HCBS program.

- Adult oral health services
- Assistive services
- Day supports
- Family/individual supports
- Medical alert-rental
- Personal assistant services
- Residential supports
- Respite care-overnight
- Respite care-temporary
- Sleep cycle support
- Supported employment
- Supportive home care
- Wellness monitoring

All HCBS MR/DD waiver services (with the exception of adult oral health services require prior authorization through the plan of care process.

Oral health services are available to adults, 21 years of age and older, who are enrolled in the HCBS MR/DD, Traumatic Brain Injury (TBI), and Physically Disabled (PD) waiver programs. Refer to Exhibit D in the Dental Provider Manual for services available for HCBS MR/DD, TBI, and PD adult beneficiaries.

Money Follows the Person Program
Effective with dates of service on and after July 1, 2008, 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. To qualify, a beneficiary must meet all of the following criteria:

1. Have resided in one of the following qualified institutional settings continuously for six months
   - Nursing Facility (NF)
   - Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)
2. Been KMAP eligible for 30 days prior to transition
3. Met functional eligibility for one of the following HCBS waivers
   - HCBS-Physical Disability
   - HCBS-Frail Elderly
   - HCBS-Traumatic Brain Injury
   - HCBS-MR/Developmental Disability

Please refer to the Money Follows the Person Provider Manual for additional information.

HCBS MR/DD Enrollment
HCBS MR/DD providers must enroll in the Kansas Medical Assistance Program (KMAP) and receive a provider number for HCBS MR/DD program services. Access provider enrollment information at https://www.kmap-state-ks.us/Public/Provider.asp.

Note: EDS supplies manuals for each HCBS MR/DD program in which the provider is enrolled.
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.
Introduction to the CMS-1500 Claim Form

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

EDS does not furnish the 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 the General Billing Provider Manual.

Submission of Claim

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

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas  66601-3571
Enter procedure code **S5125** (Supportive Home Care - MR/DD) in field 24D of the CMS-1500 claim form.

**One unit = 15 minutes.**

**Client Obligation**

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

**One Plan of Care per Month**

Prior authorizations through the plan of care process are approved for one month only. Dates of service that span two months must be billed on two separate claims.

**Example**

Services for July 28 - August 3 must be billed with July 28 - 31 on one claim and August 1 - 3 on a second claim.

**Overlapping Dates of Service**

The dates of service on the claim must match the dates approved on the plan of care and cannot overlap. For example, there are two lines on the plan of care with the following dates of service, July 1 - 15 and July 16 - 31. If billing service dates of July 8 - 16, the claim would deny because the billed dates cross plan of care segments the system is trying to read two different lines on the plan of care. For the first service line, any date that falls between July 1 - 15 will prevent the claim from denying for date of service.

**Same Day Service**

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

- Services provided the date of admission, if provided prior to admission
- Services provided the date of discharge, if provided following discharge
- HCBS Targeted Case Management provided within 30 days prior to discharge.
Supportive Home Care

Supportive home care (SHC) services are available to an HCBS MR/DD beneficiary who meets one of the following requirements:

- Lives with a person meeting the definition of family
- Is a child, five to 21 years of age, who is in the custody of the State of Kansas Department of Social and Rehabilitation Services (SRS) but not living with someone meeting the definition of family
- Is a child, 15 years of age or older, who resides in a setting with persons who do not meet the definition of family and have not been appointed the legal guardian or custodian

**Note:** Family is defined as any person immediately related to the beneficiary. Immediate-related family members are parents (including adoptive parents), grandparents, a spouse, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

SHC services provide individualized (one-on-one) direct assistance to HCBS MR/DD beneficiaries with:

- Daily living and personal adjustment
- Attendant care
- Assistance with medications that are ordinarily self-administered
- Accessing medical care
- Supervision
- Reporting changes in the beneficiary’s condition and needs
- Extension of therapy services
- Ambulation and exercise
- Household services essential to health care at home or performed in conjunction with assistance in daily living (shopping, meal preparation, clean-up after meals, bathing, using appliances, dressing, feeding, bed making, laundry, and cleaning the bathroom and kitchen)
- Household maintenance related to the beneficiary

**Note:** The SHC worker can accompany or transport the beneficiary to accomplish any of the tasks listed above or to provide supervision or support for community activities.

Limitations

- HCBS MR/DD supportive home care is available to Medicaid program beneficiaries who:
  - Are five years of age or older
  - Are mentally retarded or otherwise developmentally disabled
  - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MR/DD) screening
  - Choose to receive HCBS MR/DD rather than ICF/MR services
• HCBS MR/DD is available to minor children, five to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.

• SHC services cannot be provided by a beneficiary’s spouse or by a parent of a beneficiary who is a minor child under 18 years of age.

• SHC recipients cannot receive residential supports in addition to supportive home care or personal assistant services as an alternative to residential supports.

• SHC services cannot be provided in an educational setting, used for education, used as a substitute for educationally-related services, or used for transition services as outlined in the beneficiary’s individual education plan. In order to verify that SHC services are not used as a substitute, an SHC Services Schedule (MR-10) or an In-Home Supports Needs Assessment must clearly define the division of educational services and SHC services. Educational services must be equal to or greater than the seven hours per day of a regularly scheduled school day. These hours do not have to be consecutive hours. The minimum number of hours required for kindergarten students is seven hours per day for those eligible for full-day and three-and-a-half hours per day for those eligible for half-day.

• SHC services are limited to a maximum of an average of eight hours per day in any given month. The services are only for the activities described above unless sufficient rationale is provided for hours in excess of an average of eight hours per day in any given month.

• SHC hours are provided only when the primary care giver is present or regularly scheduled to be absent. Otherwise, respite hours should be utilized.

• A beneficiary can receive SHC services from more than one worker, but no more than one worker can be paid for services at any given time of the day.

• Waiver beneficiaries who require assistance with independent activities of daily living (IADL) tasks and who live with a capable spouse or guardian should rely on him or her for this type of informal and natural support. The only exception is if there are extenuating or specific circumstances documented in the person-centered support plan (PCSP). For example, the PCSP defines the role of the SHC provider as a person who is teaching the beneficiary how to perform a certain skill. In accordance with this expectation, SHC services should not be used for the following:
  o Lawn care
  o Snow removal
  o Shopping
  o Ordinary housekeeping (which should be done by the individual with whom the recipient lives)
  o Meal preparation (during the times when the person with whom the recipient lives would normally prepare a meal)
• SHC services cannot be provided to a beneficiary who is an inpatient of a hospital, a nursing facility, or an ICF/MR when the inpatient facility is billing Medicaid, Medicare and/or private insurance except as described below in SHC retainer services.

• SHC retainer services may be billed up to a maximum of 14 days per calendar year, at a level consistent with the approved plan of care. These services are provided during the period of time when the individual is an inpatient of a hospital, a nursing facility, or an ICF/MR when the facility is billing Medicaid, Medicare and/or private insurance. They are provided to assist individuals who self-direct their care in retaining their current care provider(s).

Provider Requirements
SHC providers must be affiliated with the community developmental disability organizations (CDDO) for the area where they operate. As indicated in K.A.R. 30-63-10, any individual providing services must be at least 16 years of age or at least 18 years of age if a sibling of the beneficiary. All individuals providing services must receive at least 15 hours of prescribed training or the person directing and controlling the services must provide written certification to the CDDO that sufficient training to meet the beneficiary’s needs has been provided. The beneficiary may choose the self-direct option for SHC. If the person is incapable of providing self-direction, the beneficiary’s guardian, family member or person acting on his or her behalf may choose.

Any entity providing attendant care, personal service, or serving as a payroll agent for attendant/personal care services must maintain a current listing of the name, address, and telephone number of all providers rendering these services.

Any entity required to maintain a current list of the name, address and telephone number of attendant/personal care persons will, upon request, make such information available to federal and state agencies, law enforcement, the attorney general’s office, and legislative post audit. If there is a dispute between the provider and a requesting entity on whether the list should be released, the state agency responsible for the program will make the final decision.

Documentation Requirements
• Recordkeeping responsibilities rest primarily with the Medicaid-enrolled provider.

• Written documentation is required for services provided and billed to KMAP.

• Documentation, at a minimum, must include the following:
  o Beneficiary’s name and signature (see signature limitations)
  o Caregiver’s name and signature
  o Complete date of service (MM/DD/YY)
  o Start time for each visit, including AM/PM or using 2400 clock hours
  o Stop time for each visit, including AM/PM or using 2400 clock hours
  o Brief description of duties performed
Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle.

Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims.

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

**Signature Limitations**

When choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided knowing the beneficiary may have limitations. A designated signatory can be anyone aware of the services provided. However, the individual providing the services **cannot** sign the timesheet on behalf of the beneficiary.

Each timesheet must contain the signature of the beneficiary or designated signatory verifying the services received and the time recorded. Approved signing options include:

- Beneficiary’s signature
- Beneficiary making a distinct mark representing their signature
- Beneficiary using their signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider must establish, document and monitor a plan based on the situation.

If a beneficiary refuses to sign accurate timesheets without a legitimate reason, he or she must be advised that the attendant’s time may not be paid or money may be taken back. Timesheets not reflecting accurate times and services must not be signed. Unsigned timesheets are the responsibility of the billing provider.
DEFINITIONS  Updated 09/08

Community Based Screening – an assessment of the adaptive needs, maladaptive behaviors, and health needs of individuals who are mentally retarded or developmentally disabled to determine their eligibility for ICF/MR level of care.

Community Developmental Disability Organizations (CDDO) - a local agency, specified by county government, which directly receives county mill funds and state aid and either directly and/or through a network of affiliates provides community-based services to individuals who are mentally retarded or developmentally disabled and is formally recognized by Disability and Behavioral Health Services/Community Supports and Services.

Affiliate - a local agency which provides at least one service to individuals who are mentally retarded or developmentally disabled and has entered into an affiliation agreement with the recognized CDDO.

Plan of Care - a document completed following the determination of ICF/MR eligibility, after the individual elects HCBS MR/DD instead of ICF/MR services. This document, subject to the approval of the HCBS-MR/DD program manager, must include:

- The services to be provided
- The frequency of each service
- The provider of each service
- The cost of each service
Expected Service Outcomes for Individuals or Agencies Providing HCBS MR/DD Services
Updated 09/08

1. Services are provided according to the plan of care, in a quality manner and as authorized on the notice of action.

2. Provision of services is coordinated in a cost-effective manner.

3. Beneficiary’s independence and health are maintained, when possible, in a safe and dignified manner.

4. Beneficiary’s concerns and needs, such as changes in health status, are communicated to the case manager or independent living counselor within 48 hours. This includes any ongoing reporting required by the Medicaid program.

5. Failure or inability to provide services as scheduled in accordance with the plan of care are reported immediately, but not to exceed 48 hours, to the case manager or the independent living counselor.
# HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05**

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<td>(Group Health Plan)</td>
<td>(Feica)</td>
<td>(Blk Lung)</td>
<td>(Other)</td>
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9. **PATIENT'S NAME**
- Last Name, First Name, Middle Initial

10. **PATIENT'S ADDRESS**
- No., Street

11. **CITY**

12. **STATE**

13. **ZIP CODE**

14. **TELEPHONE**

15. **SEX**
- M
- F

16. **BIRTH DATE**
- MM
- DD
- YY

17. **PATIENT'S employment relationship to insured**
- Self
- Spouse
- Child
- Other

18. **INSURED'S I.D. NUMBER**

19. **INSURED'S NAME**
- Last Name, First Name, Middle Initial

20. **INSURED'S ADDRESS**
- No., Street

21. **CITY**

22. **STATE**

23. **ZIP CODE**

24. **TELEPHONE**

25. **SEX**
- M
- F

26. **BIRTH DATE**
- MM
- DD
- YY

27. **PATIENT'S CONDITION RELATED TO**
- Employment (Current or Previous)
- Auto Accident
- Other Accident

28. **EMPLOYER'S NAME OR SCHOOL NAME**

29. **INSURANCE PLAN NAME OR PROGRAM NAME**

30. **IS THERE ANOTHER HEALTH BENEFIT PLAN?**
- Yes
- No

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

32. **SERVICE FACILITY LOCATION INFORMATION**

33. **BILLING PROVIDER INFO & PH #**

**NUCC Instruction Manual available at:** www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**