KANSAS MEDICAL ASSISTANCE PROGRAM

PROVIDER MANUAL

HCBS MRDD Wellness Monitoring
## BILLING INSTRUCTIONS

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## BENEFITS AND LIMITATIONS

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**HCFA-1500 CMS-1500 Form**
INTRODUCTION TO THE HCBS MR/DD PROGRAM

Updated 04/07

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 client’s choice to participate in the HCBS program.

- Adult Oral Health Services
- Communication Devices
- Day Services
- Family/Individual Supports
- Home Modifications
- Medical Alert-Rental
- Night Support
- Residential Services
- Respite Care-Overnight
- Respite Care-Temporary
- Respite Care-Emergency
- Screening
- Supportive Home Care
- Targeted Case Management
- Van Lifts
- Wellness Monitoring
- Wheelchair Modifications

All HCBS MR/DD waiver services (with the exception of Adult Oral Health Services, Screening, and Targeted Case Management) require prior authorization through the plan of care process.

Effective with dates of service on and after April 1, 2007, oral health services are available to adults age 21 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.

Enrollment: HCBS MR/DD

All HCBS MR/DD providers must enroll in the Kansas Medical Assistance Program and receive a provider number for HCBS MR/DD services. Contact EDS for enrollment.

Note: EDS supplies manuals for each HCBS MR/DD program in which the provider is enrolled.

HIPAA Compliance

As a participant in the Kansas Medical Assistance Program (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 by the Department during its review and investigation. The provider is required to provide the same forms of 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 shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
Providers must use the HCFA-1500 CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services provided under the Kansas Medical Assistance Program (KMAP). An example of the HCFA-1500 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 HCFA-1500 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 HCFA-1500 CMS-1500 are available in the General Billing Provider Manual, pages 5-14 through 5-19.

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 **S5190** in field 24D of the **HCFA-1500 CMS-1500** claim form.

**One unit = one visit.**

**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 will 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 you were to bill service dates of July 8 - 16, the claim would deny because 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 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:
- HCBS services provided the date of admission, if provided prior to consumer being admitted
- HCBS services provided the date of discharge, if provided following the consumer’s discharge
- HCBS Targeted Case Management provided within 30 days prior to discharge.
Wellness Monitoring:
Wellness monitoring is a process whereby a registered nurse evaluates the level of wellness of a consumer to determine if the consumer is properly using medical health services as recommended by a physician and if the health of the consumer is sufficient to maintain him/her in his/her place of residence without more frequent skilled nursing intervention.

Wellness monitoring is not covered for HCBS MR/DD beneficiaries when provided within the same 60-day period as skilled nursing services provided by a home health agency. Consideration will be made when documentation submitted with the claim indicates the medical need. This limitation will be monitored post-pay.

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Wellness monitoring:

1. Reduces the need for routine check-ups in a costly medical care facility
2. Determines whether the beneficiary can remain at home in his/her present condition
3. Must be provided by a licensed registered nurse in private employment, employed by a home health agency, local health department, Community Developmental Disability Center (CDDO) or affiliate

The RN who provides wellness monitoring may also provide nursing care and supervise medical attendants.

The wellness monitoring nurse must provide the case manager with a brief summary, following each visit, indicating how the beneficiary is doing under the services currently provided.
Wellness monitoring includes checking and/or monitoring the following:

- orientation to surroundings
- skin characteristics
- edema
- personal hygiene
- blood pressure
- respiration
- pulse
- adjustments to medications

Enrollment:

Private RNs must attach a copy of his/her nursing license to the provider enrollment packet.

Recordkeeping:

*Documentation Requirements:*

The wellness monitoring nurse must provide the case manager with a brief summary following each visit, indicating how the beneficiary is doing under the services currently provided. *With the consumer’s written consent, this may also be forwarded to the primary care physician as appropriate.*

Written documentation is required for services provided and billed to the Kansas Medical Assistance Program. *Documentation at a minimum must include the following:*

- Consumer’s first and last name
- Nurse’s name and signature with credentials
- Date of service (MM/DD/YY)
- Clinical Measurements
- Review of Systems
- Additional Observations, Interventions, Teaching issues, etc.

*Documentation must be created at the time of the visit. Creating documentation after-the-fact 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.*
Expected Service Outcomes For Individuals or Agencies
Providing HCBS MR/DD Services

Updated 11/03

1. Services are provided according to the plan of care 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 consumers' independence and health where possible, and in a safe and dignified manner.

4. Communicate consumer concerns/needs, changes in health status, etc., to the 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 plan of care must be reported immediately, but not to exceed 48 hours, to the Case Manager or the Independent Living Counselor.