KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

HCBS PD Personal Services
## PART II
PERSONAL SERVICES PROVIDER MANUAL

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### BENEFITS AND LIMITATIONS

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### FORMS

CMS-1500
INTRODUCTION TO THE HCBS/PD PROGRAM

Updated 06/08

The Home and Community Based Services for the Physically Disabled (HCBS/PD) waiver program is designed for Medicaid-eligible beneficiaries 16 to 64 years of age who are determined physically disabled by social security standards, excluding individuals with a diagnosis of Severe and Persistently Mentally Ill (SPMI), Severely Emotionally Disturbed (SED), or Developmentally Disabled (DD), and who are determined by qualified independent living counselors to need assistance to accomplish the normal rhythms of the day.

These beneficiaries may receive the following services:

- Independent living counseling
- Assistive services
- Personal services

All HCBS PD 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 Mental Retardation/Developmental Disabilities (MR/DD), Traumatic Brain Injury (TBI), and 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 PD Enrollment

All HCBS PD providers must enroll in the Kansas Medical Assistance Program (KMAP) and receive a provider number for HCBS PD services. Contact EDS for enrollment.

Note: EDS supplies manuals for each HCBS PD program in which the provider is enrolled.
INTRODUCTION TO THE HCBS/PD PROGRAM

Updated 06/08

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.
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
7010. PERSONAL SERVICES SPECIFIC BILLING INSTRUCTIONS
Updated 05/07

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

Enter procedure code S5126UC in field 24D of the HCFA CMS-1500 claim form.

One unit = one month.

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.

Overlapping Dates of Service:
The dates of service on the claim must match the dates approved on the plan of care and cannot overlap
Example:

An electronic Plan of Care has two detail lines: 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 8th thru 16th, will deny because it conflicts with the dates that have been approved on the electronic Plan of Care. At this time the claims system is not able to read two different lines on the Plan of Care 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 plan of care and provided the same day a consumer is hospitalized or in a nursing facility may be allowed. Situations are limited to:

- HCBS Personal Services provided the date of admission, if provided prior to consumer being admitted
- HCBS Personal Services provided the date of discharge, if provided following the consumer’s discharge
- HCBS Independent Living Counseling
- Medical Alert Services
Personal Services

Personal services means one or more persons assisting another person who has a disability with tasks that the disabled beneficiary would typically do for themselves in the absence of a disability. Such services may include assisting beneficiaries in accomplishing any activity of daily living (ADL) or instrumental activity of daily living (IADL) associated with normal rhythms of the day.

Examples of normal rhythms of the day include combinations of ADLs and IADLs:
- Assistance getting ready for work or school
- Assistance cleaning house
- Assistance with shopping
- Assistance getting ready for bed

ADLs include:
- Bathing
- Grooming
- Toileting
- Transferring
- Feeding
- Mobility
- Accompanying to obtain necessary medical services

IADLs include:
- Shopping
- Housecleaning
- Meal preparation
- Laundry
- Life management

Health maintenance activities such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion may be provided in accordance with K.S.A. 65-6201 (b)(2)(A).

Beneficiaries will have complete access to choose any qualified provider who can meet their personal service needs. Family members may be reimbursed when providing this service. However, under no circumstance will parents of minor children or spouses be paid.

No more than one personal service worker may be paid for services at any given time of the day. Exceptions must be justified and documented by the case manager, such as two-man lift for safety issues. Approval for these services will be given by the area Medicaid management staff. Medicaid nonwaivered home health aide services for HCBS PD beneficiaries require prior authorization.
Limitations
Beneficiaries on the HCBS PD waiver prior to their 65th birthday, and at anytime after, will have the option at age 65 of remaining on the PD waiver or transferring to the HCBS Frail Elderly (FE) waiver. Beneficiaries can only transfer once.

Reimbursement
Reimbursement for this service is limited to the beneficiary’s assessed level of services need. This service must be reimbursed within the approved reimbursement range established by the State.

Enrollment
All personal services will be arranged by and generally paid through the independent living counseling agency with the beneficiary’s written authorization of the purchase. Beneficiaries will have complete access to choose any qualified provider (agency or individual). The provider must be 18 years of age or older. If the qualified provider agency does not wish to contract with the independent living counseling agency, the State will provide a separate provider agreement for that provider agency. Individual qualified providers will not be given separate provider agreements but may choose to contract with any qualified provider agency or independent living counseling agency.

Provider Requirements
Medicaid providers who choose to provide payroll agent services to self-directed beneficiaries must comply with the following:

- Have a federal employer identification number and receive Medicaid payments under this number
- Withhold and deposit all applicable taxes for each employee and each attendant working with a self-directed beneficiary, including federal, state and FICA withholding
- Provide unemployment insurance on each employee and each attendant working with a self-directed beneficiary
- Provide worker’s compensation insurance in accordance with K.S.A. 44-505. Note: This coverage can be provided as a benefit, if not required by law.
- Issue an annual W-2 to each employee and each attendant working with a self-directed beneficiary
- Maintain records in accordance with all federal and state requirements
- Assist in the completion of background checks on the self-directed attendants working with the beneficiary, at the request of the self-directed beneficiary
- Provide to each self-directed beneficiary, in writing, a description of the services that will be provided to the attendant, including any benefits the attendant will receive

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
Written 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. Providers are responsible to insure service was provided prior to submitting claims.

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

In-Home Care
Documentation at a minimum must include the following:
- Identification of service being provided
- Beneficiary’s name and signature (see signature limitations)
- Caregiver’s name and signature
- 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

Time should be totaled by actual minutes and hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle.

Assisted Living Facilities, Residential Home Care Facilities, Homes Plus, and Board and Care Facilities
Documentation at a minimum must include the following:
- Identification of service being provided
- Beneficiary’s name and signature (see signature limitations)
- Caregiver’s name and signature
- Date of service (MM/DD/YY)
- Brief description of duties performed during each contact in accordance with the current service plan

Postpay reviews will be based on the description of services provided. Any service authorized on the Attendant Care Worksheet but not documented as having been performed will be subject to recoupment.
8400. Updated 09/08

Services such as transportation, lawn mowing or snow removal should be documented with an invoice or receipt that contains the following:
- Name of provider
- Complete date (MM/DD/YY) that service was provided
- Amount of bill
- Identification of the service that was provided (lawn mowing, etc)
- Beneficiary’s signature (see signature limitations)

Electronic Documentation

Documentation must at a minimum include the following:
- Identification of the HCBS waiver service being provided
- Identification of the beneficiary receiving the service(s)
- Identification of the attendant providing the service(s)
- Date of service
- Start time of the service, including AM/PM or using 2400 clock hours
- End time of the service, including AM/PM or using 2400 clock hours
- Identification of duties performed during each visit
- Beneficiary’s signature authorizing the use of the electronic documentation system at the start of service delivery

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

Signature Limitations

In all situations, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided in recognition that a beneficiary's limitations may make assistance necessary 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 timesheet on behalf of the beneficiary.

Each timesheet must have the signature of the beneficiary or designated signatory verifying that the beneficiary received the services and that the time recorded is accurate. The approved signature options include any of the following:
- 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 timesheets without a legitimate reason should be advised that the attendant’s time may not be paid or that money may be taken back. Timesheets not reflecting time and services accurately should not be signed. Unsigned timesheets are a matter for the billing provider to address.
Expected Service Outcomes for Individuals or Agencies Providing HCBS-PD 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 and quality manner.

3. Beneficiary’s independence and health are maintained, where 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 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 at least within 48 hours, to the case manager.
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Insured's ID. Number</td>
<td>For Program in Item 1</td>
</tr>
<tr>
<td>2. Patient's Name</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>3. Patient's Address</td>
<td>No., Street</td>
</tr>
<tr>
<td>4. Patient's Relationship to Insured</td>
<td>Self, Spouse, Child, Other</td>
</tr>
<tr>
<td>5. City</td>
<td></td>
</tr>
<tr>
<td>6. State</td>
<td></td>
</tr>
<tr>
<td>7. ZIP Code</td>
<td></td>
</tr>
<tr>
<td>8. Telephone</td>
<td>Include Area Code</td>
</tr>
<tr>
<td>9. Other Insured's Name</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>10. Is Patient's Condition Related to Insured?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>11. Insured's Policy Group or FECA Number</td>
<td></td>
</tr>
<tr>
<td>12. Patient's Policy Group or FECA Number</td>
<td></td>
</tr>
<tr>
<td>13. Is Insured's Condition Related to FECA?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>14. Date of Current Illness</td>
<td>MM DD YY</td>
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<tr>
<td>15. If Patient Has Had Same or Similar Illness, Give First Date</td>
<td>MM DD YY</td>
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<tr>
<td>16. Date Patient Unable to Work</td>
<td>From MM DD YY To MM DD YY</td>
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<tr>
<td>17. Name of Referring Provider or Other Source</td>
<td></td>
</tr>
<tr>
<td>18. Hospitalization Dates Related to Current Services</td>
<td>From MM DD YY To MM DD YY</td>
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<tr>
<td>19. Reserved for Local Use</td>
<td></td>
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<tr>
<td>20. Outside Lab</td>
<td>SCharges</td>
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<tr>
<td>21. Diagnosis or Nature of Illness or Injury</td>
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<tr>
<td>23. Prior Authorization Number</td>
<td></td>
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<tr>
<td>24. A. Date(s) of Service</td>
<td>From MM DD YY To MM DD YY</td>
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<tr>
<td>B. Provider ID</td>
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<td>C. Procedure, Services, or Supplies</td>
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<tr>
<td>D. Description of Services</td>
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<td>E. Diagnosis</td>
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<td>F. Diagnosis Code</td>
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<td>G. Charges</td>
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<td>H. Deductibles/Allowance</td>
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<td>I. Total Charges</td>
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<td>J. Balance Due</td>
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<td>K. Payment</td>
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<td>L. Payment</td>
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**NUCC Instruction Manual Available at:** [www.nucc.org](http://www.nucc.org)