



KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

KAN Be Healthy

PART II
KAN BE HEALTHY FEE-FOR-SERVICE PROVIDER MANUAL

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

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

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INTRODUCTION TO THE KAN BE HEALTHY PROGRAM

Updated 12/13

KAN Be Healthy (**KBH**) is a Title XIX program which provides preventive health care and immediate remedial care for the prevention, correction, or early control of abnormal conditions. It is available to beneficiaries who are 20 years of age or under. This program is referred to as Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) at the federal level. KBH is not a MediKan program. Noncovered services may be covered for KBH beneficiaries when the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) determines the services as medically necessary. Medical necessity must be presented, and prior authorization (PA) must be obtained. Program limitations on covered procedures may be exceeded when prior authorized (refer to Section 4300 of the *General Special Requirements Fee-for-Service Provider Manual*).

KBH Participation/Eligibility

Beneficiaries who are 20 years of age and under are considered KBH-enrolled participants and are eligible for the KBH program until turning 21 years of age.

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 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. KAN BE HEALTHY BILLING INSTRUCTIONS Updated 07/13

Introduction to the CMS-1500 Claim Form

Providers must use the CMS-1500 when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original red claim form and completed as indicated. Any CMS-1500 claim not submitted on the red claim form will be returned to the provider.

An example of the CMS-1500 and instructions are on the KMAP [public](#) and [secure](#) websites on the [Forms](#) page under the Claims (Sample Forms) heading.

Any of the following billing errors may cause a CMS-1500 claim to deny or be sent back to the provider:

- The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed. Claim information must be submitted in the correct fields as instructed.
- Staples on the claim form.
- A CMS-1500 claim form carbon copy.

The fiscal agent does not furnish the CMS-1500 claim form to providers.

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571

7010. KAN BE HEALTHY SPECIFIC BILLING OPTIONS Updated 06/11

There are three KBH screening billing options for the enrolled provider. For specific program requirements (minimum documentation requirements, benefits, and limitations), refer to the appropriate section in this manual.

KBH Billing: Option One

When billing modifier EP with one of the *CPT* evaluation and management (E&M) preventive medicine (99381 through 99385 or 99391 through 99395) or office visit (99202 through 99205 or 99213 through 99215) *CPT* codes, providers must conform to the following requirements:

- Bill modifier EP only with an E&M preventive medicine or office visit code.
- A wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0, and/or V70.3 through V70.9) must be billed with the E&M office visit *CPT* code, or the claim will deny and the four KBH screens will not update.
- Immunization administration, laboratory, and blood lead **analysis** can be referred to another provider if the screening agent is unable to provide. Follow referral requirements as outlined in the Referring KBH Screening Components section of this manual.
- Blood lead **collection** cannot be referred to another provider. This is a requirement of participating KBH providers.
- Rural Health Clinic (RHC) or Federally Qualified Health Care (FQHC) registered nurses (RNs) who complete a KBH screen are instructed to use modifier TD.
- Providers, including midlevel practitioners – advanced registered nurse practitioners (ARNPs) and physician assistants (PAs) – are reimbursed at the EP modifier rate. If the billing provider is an FQHC or a RHC, reimbursement is consistent with the encounter rates.

Minimum documentation of the following 12 components is required. Documentation must be maintained in the beneficiary's permanent medical record. Documentation by exception is not accepted.

KBH Billing: Option Two

E&M preventive medicine *CPT* codes 99381 through 99385 or 99391 through 99395 **without** modifier EP update the four KBH screens.

- Documentation must reflect the code's definition and be maintained in the beneficiary's permanent medical record. Documentation by exception is not accepted.
- KBH screening components that have been completed and documented are billed separately. For example, the KBH screening provider completed the documentation requirements for the E&M preventive medicine code as well as a developmental screen, hearing screen, vision screen, laboratory, and immunizations. Bill the developmental, hearing, vision screen, laboratory, and immunization codes separately from the E&M office visit code.
- Midlevel practitioners (ARNPs/PAs) are reimbursed 75% of the allowed amount.

7010. Updated 06/11

KBH Billing: Option Three

E&M office visit codes 99202 through 99205 or 99213 through 99215 with a wellness diagnosis but **without** modifier EP update the four KBH screens.

- Use an E&M office visit code when a visit was scheduled with the intent of completing a KBH screen, but abnormalities were observed and diagnosed.
- Bill a wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0, and/or V70.3 through V70.9) with the E&M office visit code to update the four KBH screens.
- KBH screening components that have been completed and documented are billed separately. For example, the KBH screening provider completed the documentation requirements for the E&M office visit code and a developmental screen, hearing screen, vision screen, laboratory, and immunizations. Bill the developmental screen, hearing screen, vision screen, laboratory (excluding blood lead), and immunization codes separately from the E&M office visit code.
- Midlevel practitioners (ARNPs/PAs) are reimbursed 75% of the allowed amount.
- Documentation by exception is not accepted.

8000. KAN BE HEALTHY Issued 03/10

KBH PERIODICITY SCHEDULE

Screening frequencies are based on the 2007 American Academy of Pediatrics (AAP) “Recommendations for Preventive Pediatric Health Care” as published on the AAP website, as of November 5, 2007. The first screen may be performed at any age under 21 and repeated according to ideal timeframes listed in the KBH Screening Frequencies table below. When the ideal schedule is not possible to follow, please note KBH medical screens may be completed at any time.

Note: Every KBH visit must have all components completed and documented.

Medical Screenings

(M) Medical screens follow the KBH minimum documentation requirements which include the hearing, vision, and dental screening.

Dental Screenings

(D) Dental screens are a required component of each KBH visit based on both the Kansas State and AAPD/ADA/AAP Periodicity Schedule.

Vision Screenings

(V) Vision screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School vision screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Vision Screening Guidelines.

Hearing Screenings

(H) Hearing screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School hearing screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Hearing Screening Guidelines and Resource Manual.

KBH Screening Frequencies
Age with Type of Screens Due

Birth: M, V, H	Two to five days after birth: M, V, H	One month: M, V, H
Two months: M, V, H	Four months: M, V, H	Six months: M, V, H
Nine months: M, V, H, D	12 months: M, V, H, D	15 months: M, V, H, D
18 months: M, V, H, D	24 months: M, V, H, D	30 months: M, V, H, D
Yearly three - 20 years: M, V, H, D		

8000. Updated 10/14

KBH SCREENING PROVIDERS

KBH Screening Providers

The following KMAP providers may complete KBH screens:

- Physicians
- Dentists (KBH dental screens)
- PAs
- ARNPs
- RNs

Note: RNs cannot independently enroll for reimbursement as KMAP providers.

Reimbursement for KBH Screens

KBH screens will be reimbursed when performed by any of the above and billed by:

- ARNP
- Attendant Care for Independent Living
- Community Mental Health Center
- FQHC
- Head Start facility
- Home Health Agency
- Indian Health Center
- Local Education Agency
- Local health department (LHD)
- Physician
- Physician assistant
- RHC

KBH SCREENING GUIDE

KBH screening providers have multiple options to bill for, be reimbursed for, and ensure that the beneficiary's KBH screens update appropriately. The billing options include:

- An evaluation and management (E&M) preventative medicine *CPT* code (99381 through 99385 or 99391 through 99395) with modifier EP
- An E&M office visit *CPT* code (99202 through 99205 or 99213 through 99215) with modifier EP and wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0 and/or V70.3 through 70.9)
- An E&M preventative medicine *CPT* code without modifier EP
- An E&M office visit *CPT* code without modifier EP and with wellness diagnosis code

Note: There are additional *CPT* codes that will update one KBH screen only; additional *CPT* codes update one medical, dental, vision, or hearing KBH screen.

The following guide will initially review the above first and second KBH screen billing options and the minimum documentation requirements. KMAP uses modifier EP for its federally mandated EPSDT program, which is also known as KAN Be Healthy. Modifier EP not only identifies that the provider has met minimum documentation requirements, but also that a set EP modifier rate should be paid. See below and review additional outlined directives when billing modifier EP and an E&M preventative medicine or office visit *CPT* code.

8000. Updated 06/11

E&M PROCEDURE CODES WITH MODIFIER EP

Modifier EP Directives

- Modifier EP indicates that all twelve of the KBH screening components are minimally documented.
- Modifier EP can only be billed with an E&M preventative medicine (99381-99385 or 99391-99395) or office visit (99202-99205 or 99213-99215) *CPT* code.
- Billing an E&M office visit *CPT* code and a wellness diagnosis code (V20-V20.2, V20.31, V20.32, V70.0, and/or V70.3-70.9) is encouraged when the intent of the scheduled visit was a KBH screen and an abnormality was diagnosed.
- E&M office visit *CPT* codes must be billed in conjunction with at least one wellness diagnosis code (V20-V20.2, V20.31, V20.32, V70.0 and/or V70.3-70.9).
- When an office visit *CPT* code is billed with modifier EP without a wellness diagnosis, the service will be **denied** and the KBH screens will not update.
- Screening providers are reimbursed at the EP modifier rate.
- ARNP/PA providers will be reimbursed at the EP modifier rate when an E&M preventative medicine or office visit *CPT* code is billed with modifier EP. All other *CPT* codes billed by an ARNP/PA provider will continue to be paid at 75% of the maximum reimbursement amount. (RHC & FQHC providers continue to receive their usual and customary encounter reimbursement rate.)
- Blood lead level collection cannot be referred to another provider. This is a requirement of participating KBH providers.
- Immunization administration, laboratory, and blood lead level analysis can be referred to another provider if the screening agent is unable to provide. Follow referral requirements as outlined in the Referring KBH Screening Components section.
- No other KBH screening component, other E&M *CPT* preventative medicine and/or office visit code without modifier EP, may be billed separately other than immunization administration and laboratory (excluding blood level poisoning testing) components.
- If a KBH screening component, other E&M preventative medicine, and/or office visit *CPT* code without modifier EP is billed on the same date of service as an E&M preventative medicine or office visit *CPT* code and modifier EP, only the first detail (first line or first claim processed) will be paid, and all following details will be denied.

8000. Updated 06/11

Billing E&M Preventative Medicine or Office Visit CPT Codes	Modifier EP	Other Component Parts or CPT Visit Billed	Diagnosis Code	KBH Screens Updated	Claim Status*	Payment Amount
E&M preventative medicine CPT code	WITH	No	Any	All Four	Paid	EP rate
E&M preventative medicine CPT code	WITH	Yes	Any	Depending upon initial detail processed.	Initial detail paid.	Depending upon initial detail processed.
E&M office visit CPT code	WITH	No	Wellness	All Four	Paid	EP rate
E&M office visit CPT code	WITH	No	Not Wellness	None	Denied	\$0.00
E&M office visit CPT code	WITH	Yes	Wellness	Depending upon initial detail processed.	Initial detail paid.	Depending upon initial detail processed.
E&M preventative medicine CPT code	WITHOUT	Yes	Any	All Four	Paid	Usual rate (ARNP/PA @ 75%)
E&M office visit CPT code	WITHOUT	Yes	Wellness	All Four	Paid	Usual rate (ARNP/PA @ 75%)
E&M office visit CPT code	WITHOUT	Yes	Not Wellness	None	Paid	Usual rate (ARNP/PA @ 75%)

*Please note, that the above claim status is an example when KMAP benefits and limitations are met.

8000. Updated 06/11

KBH Screening Components Minimum Documentation

A KBH screen must consist of at the minimum:

1. Medical History
 2. Physical Growth
 3. Body Systems
 4. Developmental/Emotional
 5. Nutrition
 6. Health Education & Anticipatory Guidance
 7. Blood Lead
 8. Laboratory
 9. Immunizations
 10. Hearing Screening
 11. Vision Screening
 12. Dental Screening
- Documentation must be maintained in the beneficiary's permanent medical record.
 - Blood lead level collection cannot be referred to another provider. This is a requirement of participating KBH providers.
 - Immunization administration, laboratory, and blood lead level analysis can be referred to another provider if the screening agent is unable to provide. Follow referral requirements as outlined in the Referring KBH Screening Components section.
 - When it is not possible to complete a screening component(s), document the reason, such as due to lack of patient cooperation, diagnosed sickness, or physical/mental handicap. Scheduling a follow-up visit is encouraged to complete the screening components. Components must not be left blank or undocumented. NA (not appropriate) and generalized documentation, such as Physical WNL, is not acceptable documentation.
 - Documentation by exception is not accepted.

The twelve KBH screening components must follow the minimum documentation requirements listed when billing an E&M preventative medicine or office visit *CPT* code with modifier EP. Providers who elect to bill using multiple *CPT* codes rather than using the modifier EP must also satisfy the documentation requirements found within the *CPT* codebook.

1. Medical History

Obtain the beneficiary's family and self-history information at the time of the initial screen and update as needed and maintain in the medical record.

- Family history, which includes parent, grandparent, and sibling, must include: allergies (food and drug), birth defects, blood disorders, cancer, diabetes, drug or ETOH abuse, heart disease/stroke, high blood pressure, kidney/liver disease, lung disease, mental illness, obesity, epilepsy/seizures, scoliosis/arthritis, speech, visual, or hearing problems, ulcers/colitis, urinary/bowel, and any other significant information
- Self-history must include the minimum: allergies (food and drug), birth history (if known), serious illness/accidents, operations, and medications as well as any other significant information

8000. Issued 03/10

2. Physical Growth

- Record a head circumference for beneficiaries less than two years of age at each screen.
- Maintain a growth chart for the recumbent length or standing height, weight, and head circumference and update at each screen. After age two, include a calculated body mass index (BMI) percentile at each screen. Beneficiaries with a greater than or equal to 85% ranking on the Center for Disease Control body mass index-for-age percentiles chart must receive recommendations regarding appropriate nutrition and physical activity from the KBH screener. This must be reflected in the documentation at the time of the KBH screen.
- Blood pressure is required for beneficiaries three to 20 years of age.
- Full set of vital signs, as indicated.

3. Body Systems

- Perform a comprehensive, unclothed physical screen including height and weight at each screen.
- Complete and document a screen of the gastrointestinal, central nervous system, musculoskeletal, integumentary, cardiovascular/pulmonary, and genital/urinary systems at each KBH screening visit.

Cardiovascular/Pulmonary

- Documentation must minimally include: heart rate (pulse), heart tones, and lung sounds.
- Document blood pressure on beneficiaries three years of age and older at each screen.

Genital/Urinary

Documentation observations must minimally include:

- Tanner stage of development
- History of or current enuresis
- Evaluation of excessive menstrual bleeding

4. Developmental/Emotional

Every child is required to have developmental surveillance at every KBH screen. Provision of developmental surveillance at every KBH screen allows for consistent surveillance and a strategy to measure, document, and circumvent serious developmental challenges.

Beneficiaries under six years of age:

A standardized developmental screening tool(s) must be completed, interpreted, and the report must be documented at each KBH screen and be maintained in the beneficiary's permanent medical report. The American Academy of Pediatrics (AAP) identified in their 2006 policy statement that the Denver Developmental Screening Test II (DDST II) has a low to moderate sensitivity and specificity rating.

Examples of more sensitive and specific screening tools that may be used are:

- Ages and Stages Questionnaires (ASQ) – also available in Spanish, French, and Korean for use with children four months to five years of age.
- Parent's Evaluations of Developmental Status (PEDS) – also available in Spanish and Vietnamese for use with children birth to eight years of age.

8000. Issued 12/13

- Modified Checklist for Autism in Toddlers (MCHAT) – also available in Spanish, Turkish, Chinese, and Japanese for use with children 15 to 30 months of age.
 - If a child is being seen regularly and developmental surveillance is provided at every KBH visit, use the MCHAT tool during the above time frames to assess for speech language developmental delays and/or autism spectrum disorders.
 - If, however, the child is only being seen sporadically, both a general developmental tool and the MCHAT should be administered at the above time frames to ensure appropriate developmental milestones are being met and to rule out potential speech language developmental delays and/or autism spectrum disorders.

Beneficiaries age six years and up must have either one or both of the following:

- Document general developmental and emotional observations, which must minimally include information regarding: exercise, sleep habits, emotional, peer interaction, school (grade, average grades, days missed, vocational, and special education/needs), and any other significant information as needed.
- A standardized developmental screening tool(s) with interpretation and report. An example of a screening tool for six years of age and older is the Pediatric Symptom Checklist (PSC). The completed report and tool must be maintained in the beneficiary's permanent medical record, as well as any referrals for services.

5. Nutrition

Complete a nutritional screen, and document the nutritional intake and status at each screen, which could include: WIC participation, breast feedings/type of formula (amount and/or how often), diet history, twenty-four hour recall, food allergies, anemia, supplements, vitamins, and potential for being overweight. Documentation such as “eats good” or “picky eater” is not appropriate.

Note: Recent studies support both the physical and emotional benefits of breastfeeding for a minimum of one year. The initiation and maintenance of breastfeeding present challenges to many mothers regardless of age, race, economic status, or family size. However, babies most in need of the benefits that breastfeeding provides are frequently from the lowest socio-economic group. Breast milk is economical and readily available on demand. If mother and child are separated for periods of time due to job responsibilities, breast milk can be pumped and stored. Breast pumps are available with a prescription from a physician and are available through a durable medical equipment (DME) provider. Refer to the *DME Fee-for-Service Provider Manual* for additional details. Additionally, La Leche Leagues and many community hospitals provide free lactation and peer support.

6. Health Education and Anticipatory Guidance

This component must include education regarding the child's development, benefits of healthy lifestyles, and accident and disease prevention. Provide diet instruction as necessary. Provide or refer family planning services as indicated. Education and discussion in this area must be age-based. Documentation must minimally include topics discussed. If any referrals result from this interaction, these are also to be documented.

8000. Issued 03/10

7. Blood Lead

All children are considered at high risk and must be screened for lead poisoning. Centers for Medicare and Medicaid Services (CMS) requires that all children receive a screening blood lead test at both 12 and 24 months of age. Children between the ages of 36 and 72 months of age, who have not received a blood lead test previously, must receive a screening blood test.

A blood lead test result equal to or greater than 10ug/dl obtained by capillary specimen (finger stick) must be confirmed by collecting a venous blood sample.

Documentation supporting blood lead poisoning, risk-factor, verbal screening and testing, including results, must be maintained in the beneficiary's permanent file. Verbal screening utilizing the KBH Mandatory Blood Lead Screening Questionnaire is mandatory at each KBH screen between the ages of 6 and 72 months. This form can be found on the [Forms page](#) of the KMAP website.

Contact the Kansas Healthy Homes and Lead Hazard Prevention Program (KS HHLHPP) – KDHE regarding blood lead poisoning, additional screening information and/or testing information at: 1000 SW Jackson Street, Suite 330, Topeka, Kansas 66612-1274, by phone at 866-865-3233, or by fax at 785-296-5594. Their email address is lead@kdhe.state.ks or <http://www.unleadedks.com/>.

Testing supplies may be ordered through the KDHE laboratory at 785-296-1623.

The Kansas Division of Health and Environmental Laboratories (DHLE) blood lead sample methodologies include: collection of a venous sample, collection of a capillary sample using a capillary tube (microtainer or vacutainer), collection of a capillary sample placing blood drops on filter paper, and collection of a capillary sample and using the lead care analyzer. Supplies must be ordered on a Requisition for Laboratory Specimen Kits form available on the Kansas Healthy Homes and Lead Hazard Prevention Program (KS HHLHPP) [website](#).

Additionally, the requisition is in on the [Forms page](#) of the public and secure websites. Copy and use to insure sufficient supplies are available to perform mandatory blood lead testing.

The six blood lead poisoning verbal screening questions are:

Does your child:

1. Live in or visit a house or apartment built before 1960? (This could include a day care center, preschool, or the home of a baby-sitter or relative.)
2. Live in or regularly visit a house or apartment built before 1960 with previous, ongoing, or planned renovation or remodeling?
3. Have a family member with an elevated blood lead level?
4. Interact with an adult whose job or hobby involves exposure to lead? (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and making pottery)

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5. Live near a lead smelter, battery plant, or other lead industry? (Ammunition/explosives, auto repair/auto body, cable/wire striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten metal [foundry work])
6. Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?

One positive response to the above questions requires a blood lead level (BLL) test.

Ask any additional questions that may be specific to situations that exist in a particular community.

Results received from verbal blood lead screenings must be recorded on the KBH Mandatory Blood Lead Screening Questionnaire located on the [Forms page](#) of the KMAP website. This form must be maintained in the beneficiary's medical record.

8. Laboratory

Complete blood count with automated differential (85025):

- Infants, once between the ages of nine and 12 months, perform and document the initial screen results
- Adolescent males
 - Routinely at age 15, perform and document the screen results
 - Annually thereafter if any of the following apply:
 - A student athlete
 - A vegetarian
- Adolescent females
 - Routinely at the age of menarche, perform and document the screen results
 - Annually thereafter if any of the following apply:
 - History of heavy menstrual flow (soaking more than three pads per day)
 - A student athlete
 - A vegetarian

9. Immunizations

Immunizations must be reviewed at each screen and brought up to date as necessary, according to age and health history. A complete record must be maintained in the beneficiary's medical record.

Refer to the most current immunization schedule recommendations from the [National Center for Immunization and Respiratory Disease \(NCIRD\)](#).

If a Vaccines for Children (VFC) provider, use the VFC stock for Medicaid and S-CHIP beneficiaries. Contact [KDHE](#) at 785-296-1500.

8000. Updated 10/14

IMMUNIZATION ADMINISTRATION

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

ADMINISTRATION CODES

90460	90471	90472	90473	90474
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VFC VACCINE CODES

90633	90634	90644	90645	90646	90647	90648	90649	90650
90653	90654	90655	90656	90657	90658	90660	90669	90670
90672	90680	90681	90685	90686	90687	90688	90696	90698
90700	90702	90703	90707	90710	90713	90714	90715	90716
90720	90723	90732	90733	90734	90743	90744	90748	Q2035
Q2036	Q2037	Q2038	Q2039					

All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are covered.

10. Hearing Screening

Documentation must include either a paper hearing screen or a qualified hearing screen, identified as the following:

- Paper Screen Option
The following paper hearing screen forms must be maintained in the beneficiary's permanent medical record. Each form is available on the [Forms page](#) of the KMAP website. Documentation must include interpretation and/or results.
 - Birth to four years of age, both forms below are required:
 - Risk Indicators for Hearing Loss Checklist
 - Hearing Developmental Scales
 - Over four years of age, the Hearing Health History form is required.

In the event the KBH screener determines that the beneficiary has not passed the paper hearing screen, a referral for further evaluation is required. The Kansas Chapter of the AAP recommends the following testing procedures for further evaluation.

- Birth to two years of age, an Auditory Brainstem Response (ABR) or Otoacoustic Emissions (OAE) is recommended.
- Two to four years of age, play audiometry is recommended.
- Over four years of age, conventional audiometric screening is recommended.
- Hearing Screening Procedure Option
The following procedures qualify as an allowed KBH hearing screen:
 - Audiometric sweep screen for beneficiaries age four years of age and up
 - Screening test, pure tone, and air only
 - Pure tone audiometry
 - Pure tone audometry – air and bone
 - Speech audiometry – threshold only
 - Speech audiometry with speech recognition

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- Comprehensive audiometry threshold evaluation
- Conditioning play audiometry
- Evoked otoacoustic emissions: limited (single stimulus level, either transient or distortion products)

Note: Documentation must include testing parameters, interpretation, and results.

11. Vision Screening

Birth to three years of age:

1. Ocular history
 - Parental observation including the following questions:
 - Does your child seem to see well?
 - Does your child hold objects close to his or her face when trying to focus?
 - Do your child's eyes appear unusual?
 - Do your child's eyelids droop or does one eyelid tend to close?
 - Has one or both of your child's eyes ever been injured?
 - Review family history
2. Eye tracking – ability to fix and follow objects
3. External inspection of the eyes and lids – penlight evaluation of the lids, conjunctiva, sclera, cornea and iris
4. Ocular motility assessment – testing for strabismus with the cross cover test
5. Pupil examination – equal, round and reactive to light
6. Corneal light reflex

Three years of age and older:

1. Ocular history
 - Parental observation including the following questions:
 - Does your child seem to see well?
 - Does your child hold objects close to his or her face when trying to focus?
 - Do your child's eyes appear unusual?
 - Do your child's eyelids droop or does one eyelid tend to close?
 - Has one or both of your child's eyes ever been injured?
 - Review family history
2. Vision assessment
 - a. Children three to four years of age – LH symbols and Allen cards
 - If three-year-old child is unable to do in two attempts, repeat in four to six months.
 - If four-year-old child is unable to do in two attempts, repeat in one month.
 - If either remains unable, refer to appropriate specialist.
 - b. Children four years of age and older – wall charts including Snellen letters or numbers or tumbling E and near acuity cards
 - c. Vision testing machines

Note: If using this option, the results of the vision test must be documented, not just the fact that the machine was used to test.
3. External inspection of the eyes and lids – penlight evaluation of the lids, conjunctiva, sclera, cornea and iris

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4. Ocular motility assessment – testing for strabismus with the cross cover test
5. Pupil examination – equal, round and reactive to light
6. Red reflex examination – view pupil from 12-18 inches from the eye in a darkened room (Bruckner Test)
7. Eye tracking – ability to fix and follow
8. Attempt at ophthalmoscopy

12. Dental Screening

Document must include minimal documentation of oral and dental observations while completing a KBH screen. At each KBH screen, a determination must be made whether or not the child has been examined by a dentist. If no dentist has been involved in the child's care by age one, a dental referral must be made by the KBH screener and documented in the medical record. The State of Kansas strongly recommends every child have a dental home with annual dental exams. Additionally, two periodic dental visits are allowed per year.

Note: A screen of the oral/dental cavity during a KBH medical screen does not constitute a comprehensive dental exam.

Additionally, physicians (general practitioners, pediatricians and family practice physicians), nurse practitioners and physician assistants may provide topical application of fluoride (prophylaxis not included) for children. This service is limited to three applications per beneficiary per calendar year. Claims may be submitted using procedure code D1203 on the CMS-1500 claim form.

Note: This policy does not apply to LHDs or FQHCs.

KAN BE HEALTHY PROVIDER RESPONSIBILITIES

8000. Updated 06/11

E&M PROCEDURE CODES

UPDATE ALL FOUR KBH SCREENS WITHOUT MODIFIER EP (bill customary charges)

KBH screens will continue to update when an E&M preventative medicine or office visit *CPT* code, without modifier EP, is billed. The following guidelines must be followed in order to update the KBH screens.

- Documentation must support the procedure code claimed. KMAP encourages reviewing and ensuring documentation meets AMA procedure code guidelines found within the latest edition of the *CPT* codebook.
- E&M office visit *CPT* codes must be billed with a wellness diagnosis (V20-V20.2, V20.31, V20.32, V70.0, and/or V70.3-70.9) in order to update the KBH screens.
- In order to maximize reimbursement, additional KBH screening components may be billed separately only when billing an E&M preventative medicine or office visit *CPT* code **without** modifier EP. Additional component examples may include: vision screen, developmental screen, and hearing screen.
- Refer to provider manuals and review benefits and limitations.

E&M PREVENTATIVE MEDICINE PROCEDURE CODES (without modifier EP)

99381	99382	99383	99384	99385
99391	99392	99393	99394	99395

E&M OFFICE VISIT PROCEDURE CODES (WITHOUT MODIFIER EP)

E&M office visit procedure codes must be billed with a wellness diagnosis (V20-V20.2, V20.31, V20.32, V70.0, and/or V70.3-70.9) in order to update the KBH screens.

New Patient - Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

99202	99203	99204	99205
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Established Patient - The following office or other outpatient visit procedure codes for the evaluation and management of an established patient require at least two of the three key components listed. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

99213	99214	99215
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When the primary diagnosis is pregnancy with procedure codes 99056, 99058, 99281, 99202-99205, and 99213-99215 the KBH medical screen will update once every 270 days (nine months).

8000. Updated 06/11

PROCEDURE CODES THAT UPDATE THE KBH MEDICAL SCREEN ONLY

(Bill customary charges)

59400	59409	59410	59425	59426
59510	59514	59515	59610	59612
59614	59618	59620	59622	99221
99222	99223	99291	99295	99431
99432	99435			

PROCEDURE CODES THAT UPDATE THE KBH HEARING SCREENS ONLY

(Bill customary charges)

92556	92557	92582	92587	
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PROCEDURE CODES THAT UPDATE THE KBH VISION SCREENS ONLY

(Bill customary charges)

92002	92004	92012	92014	99173
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PROCEDURE CODES THAT UPDATE THE KBH DENTAL SCREENS ONLY

(Bill customary charges)

D0120	D0140	D0150	D0170	D9420
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KBH REFERRAL RESPONSIBILITIES

Referring KBH Screening Components

Newly enrolled beneficiaries may be referred for KBH screens by the local Kansas Department for Aging and Disability Services (KDADS) office, an outreach agency, another provider, or the beneficiary may request a screen without being referred. A referral is required if a provider other than the beneficiary's primary care case manager completes the KBH screen. The primary care case manager can choose whether to perform KBH screens or refer them to another KMAP enrolled provider.

When billing an E&M preventative medicine or office visit procedure code with modifier EP, the only two components that may be referred, in order to complete the screen, is immunization administration and laboratory (excluding blood level poisoning testing). Referrals must be documented. Referral documentation must include: the component referred, the provider referred to, and the expected date in which the component will be completed.

Screening providers are encouraged to request the outcome results, and maintain the documentation in the beneficiary's medical record. For example, a beneficiary was referred to a LHD to update their immunizations. After administering the immunizations, the LHD is encouraged to provide the updated immunization record to the beneficiary and/or their primary care case manager.

Referrals for Diagnosis or Treatment

Screening providers should initiate diagnosis and treatment, as their license allows, or refer to another provider(s) who is (are) able to diagnose and provide treatment. Dental and optometric services as well as referrals to a physician who will be able to provide a medical home for continued preventative care, diagnosis, or treatment needs is encouraged.

Refer those potentially eligible to the Services for Children With Special Health Care Needs (Special Health Services - SHS).

KBH Referral Values and How to Claim

KBH referral values are utilized for CMS reporting purposes. Reference the referral values, definitions, and billing instructions below.

When a referral value is present, KBH indicator value (E or B) must also be present. Document one referral value per submitted claim as applicable. Referral values are utilized after a KBH screen has been completed.

- AV: Upon completion of the KBH screen, the screen provider initiated a referral; the beneficiary refused this referral.
- ST: A new referral request has been initiated and the beneficiary accepted the referral.
- S2: An abnormality was observed during the KBH screen; however, the beneficiary is currently under treatment for the observed condition.

Note: Submitting a paper claim or an electronic claim in an 837 Professional format is encouraged.

8000. Issued 03/10

CMS-1500 claim form: Referral values are to be claimed in Field 24H. In the shaded area, enter the KMAP provider ID or taxonomy code of the rendering physician. In the nonshaded area, enter the NPI of the rendering physician. The appropriate ID qualifier also needs to be entered in field 24I, ‘ZZ’ for taxonomy code and ‘ID’ for KMAP provider ID.

837 Professional Claim: Document the referral value within the X12 claim level 2300 loop. Within loop 2300, there are multiple segments. KBH referral values should be billed in the CRC Segment with appropriate data elements as follows:

- CRC01: ZZ
- CRC02 : Y
- CRC03: the appropriate referral value, which is AV, ST, or S2. HIPAA has labeled this CRC segment with the name of “EPSDT Referral.”

Additional Referral Responsibilities

- Ensure the beneficiary (or parent/guardian) is informed the nature and purpose of the referral.
- Provide the beneficiary (or parent/guardian) with the name of an appropriate provider(s).
- Ensure an appointment is made either by your office or by the beneficiary.
- Inform the provider about the condition for which the beneficiary is being referred (and that the beneficiary is a KBH participant), verbally or in writing.
- A report of the service provided must be returned to the primary care case manager.
- Suggest other resources if noncovered services are needed (such as local school district for speech evaluation/therapy).

KBH INDICATOR VALUES

KBH and Family Planning indicator values are used for reporting purposes. Reference the indicator values, definitions, and billing instructions below.

- KAN Be Healthy (EPSDT) indicator: E
- Family Planning indicator: F
- KAN Be Healthy (EPSDT) and Family Planning indicator: B

CMS-1500 claim form: Document the appropriate indicator value in Field 24H.

837 Professional Claim: KBH indicator within the: 2400 Loop, SV111 data element: Y. When the visit contains KBH and a family planning service also document a ‘Y’ within the 2400 Loop, SV112 data element.

8000. Updated 07/14

POSITIVE BEHAVIOR SUPPORTS SERVICES

Three Positive Behavior Supports (PBS) services were created for KBH beneficiaries.

These services are:

PBS Environmental Assessment: An assessment of environmental events, antecedents, and consequences that are associated with or maintain the behaviors of interest, including physiological responses. This service should be billed as H2027. A unit is equal to 15 minutes and up to 30 hours are covered per year.

PBS Treatment: Procedures that include environmental manipulation of one or more of the following: antecedent events, setting events, consequent events, and teaching new skills. This service should be billed as H2027 (U3). A unit is equal to 15 minutes and up to 60 hours are covered per year.

PBS Person-Centered Planning: The use of person-centered planning approaches that integrate a person's desired quality of life, taking into account barriers to achievement. This service should be billed as 90882 (U3). 15 minutes is equal to one unit, and up to 40 hours are covered per year.

The following conditions apply with respect to these services:

- The community developmental disabilities organizations (CDDOs) are the only provider type allowed for reimbursement of these services.
- Individuals providing PBS services must have, at a minimum, a bachelor's degree and have completed the Kansas Institute for Positive Behavior Supports (KIPBS) training program.
- To receive PBS services, the beneficiary must be a KBH beneficiary with a current screen who has obtained prior authorization through the process developed and implemented by KIPBS staff, University of Kansas.
Note: Typically, the delivery of services will be limited to one billing cycle per beneficiary (the allowable hours of assessment, treatment, and person-centered planning that can be used during a one-year billing cycle).
- There may be occasions when a case is determined to be so severe that a subsequent year of service is required. If this occurs, an exception may be considered. All exceptions must receive prior authorization using the process developed and implemented by KIPBS staff, University of Kansas.

Note: If the limitation of allowable hours of assessment, treatment, and person-centered planning has not been used during the first year of service, the remaining allotment of billable hours cannot be carried over into the second year as part of any new prior authorized service for an exception. All services approved by the KIPBS prior authorization system as part of an exception will constitute a new service arrangement for a beneficiary with specific limitations and conditions. Once prior authorization is approved for an exception and the one year billing cycle expires, further exceptions will not be considered.

8000. Updated 12/12

All PBS services must be authorized through the KIPBS prior authorization system. The following conditions apply:

- Only persons who have successfully completed the KIPBS training system and are currently recognized by that system as approved for reimbursement can make application to the KIPBS prior authorization system.
- The [KIPBS prior authorization application](#) is available. Prior authorization may also be obtained by calling the KIPBS project coordinator at 785-864-4096.
- The KIPBS Prior Authorization team takes action on each application within 48 hours whenever possible.
- If the KIPBS Prior Authorization team approves an application, it is faxed to the appropriate fiscal agent contact person for action. KIPBS will also send notification to the PBS facilitator to forward a copy of their Notice of Action on Prior Authorization document to the appropriate parties.
- All approved applications constitute an agreement on the part of the service provider to deliver all PBS services in a comprehensive and integrated fashion. For example, person-centered planning, assessment, and intervention should not be separated whenever possible to specialized personnel.
- Service providers maintain internal documentation systems that comply with all necessary regulations and laws pertaining to confidentiality and privacy protection. For all PBS services, documentation for billing should be in quarter of an hour increments. The PBS service provider must maintain a record of the individuals to whom he or she provides services that shows:
 - Name of the individual receiving the service
 - Date the service was provided
 - Name of the provider agency
 - Name of the individual providing the service
 - Location at which the service was provided
 - Type of PBS treatment provided
 - Amount of time it was provided to the nearest quarter hour

OTHER KMAP PROVIDER RESPONSIBILITIES & KBH BILLING GUIDELINES

Report Next KBH Screening Date to Beneficiary

Inform the beneficiary when their next screen is due. Notify the beneficiary when it is time to make an appointment. Children eligible for foster care services require a special written report. The foster parent or KDADS worker will provide the form.

File the KBH Screen as Soon as Possible

Providers who perform KBH screens are requested to file their claims as soon as possible. KBH screens are updated under the following conditions:

- A CMS-1500, electronic claim, or ADA dental claim form (dental claims only) submitted by an enrolled KMAP provider
- A claim with a KBH program recognized procedure code
- When the claim adjudicates (paid or denied)
Note: Adjudicated (paid or denied) claims are used to update the beneficiary's screening dates and report to CMS, as required.

8000. Updated 12/13

Additional KBH Information

- The initial newborn assessment in the hospital is automatically considered a screen under the following conditions: if the physician bills for his professional services and an appropriate procedure code that will update the KBH screen was billed. The hospital inpatient record is not considered a KBH medical screen.
- The AVR may be used to inquire if or when a beneficiary was screened. (See Section 1200 of the *General Introduction Fee-for-Service Provider Manual* for more information.)
- If a claim for a screen has been processed, the provider can verify the date of the last screening through any of the eligibility verification options. See Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for complete information on plastic medical cards and eligibility verification. For beneficiaries who will be 21 years of age or older when the next medical screen is due, the next screening date will be populated with the day before their date of birth, the day before turning 21 years of age. Beneficiaries are eligible to participate in the KBH program until the day before turning 21 years of age.
- The KBH EPSDT Screening Form provided may be duplicated for your use. This form is not required. However, if this form is properly completed, all KMAP documentation guidelines are met.
- RHC & FQHC RNs who complete a KBH screen must continue to bill modifier TD for all KBH-related services.
- KBH medical, vision, and/or hearing screens may be submitted electronically or on the CMS-1500 claim form. KBH dental screens are submitted on the ADA dental claim form.

STATE INSTITUTION KBH BILLING GUIDELINES

State institutions providing medical screens should:

- Complete the CMS-1500 claim form.
- Use an appropriate KBH screening procedure code.
- Enter the customary charge for the procedure in Field 24F of the claim form.
- Submit the claim using the institution's provider number.

Billing KBH screening claims will not result in payment to the state institution. However, the beneficiary's KBH screening dates will update and the claim information will be used for KMAP-required reporting purposes.

Note: See the [Forms page](#) of the KMAP website for an example of the KBH Screening Form.

APPENDIX

Sleep Study and Polysomnography Services Criteria Updated 01/14

1.0 Description of the Procedure, Product, or Service

Sleep studies and polysomnography refer to attended services for the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours. Sleep studies and polysomnography are performed with physician review, interpretation and report. Sleep studies and polysomnography are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP).

1.1 Polysomnography

Polysomnography is the scientific evaluation of sleep that involves a physiologic recording in a specialized facility. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging.

1.2 Sleep Study

A sleep study does not include sleep staging. A sleep study may involve simultaneous recording of ventilation, respiratory effort, electrocardiogram (EKG) or heart rate, and oxygen saturation.

1.2.1 Multiple Sleep Latency Test

- Measures daytime sleepiness.
- The instruction is to try to fall asleep.
- Involves four to five, 20-minute recordings of sleep-wake states spaced at 2- hour intervals throughout the day.

1.2.2 Maintenance of Wakefulness Test

- Measures daytime sleepiness.
- Involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

2.0 Eligible Recipients

2.1 General Provisions

Kansas Medicaid recipients must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

Sleep Study and Polysomnography Services Criteria Updated 01/14

2.2 EPSDT Special Provision: Exception to Limitations for Recipients under 21 Years of Age (continued)

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- a. That is unsafe, ineffective, or experimental/investigational.
- b. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

3.0 When the Procedure, Product, or Service Is Covered

Note: This service is not covered by Kansas Medicaid, but consideration is given to EPSDT beneficiaries under 21 years of age for medically necessary services.

3.1 General Criteria

Procedures, products, and services are covered when they are medically necessary and all of the following:

- a. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- b. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.
- c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Sleep Study and Polysomnography Services Criteria Updated 01/14

3.2 Specific Criteria

A supervised polysomnography or sleep study performed in a sleep laboratory may be considered medically necessary as a diagnostic test in patients who present with one of the following:

3.2.1 Narcolepsy

- Narcolepsy is a syndrome that is characterized by abnormal sleep tendencies (excessive daytime sleepiness, disturbed nocturnal sleep, inappropriate sleep episodes or attacks).
- Polysomnography or sleep studies are covered as a diagnostic test for narcolepsy when the condition is severe enough to interfere with the patient's well-being and health.
- Ordinarily, a diagnosis of narcolepsy can be confirmed by three sleep naps.

3.2.2 Sleep Apnea

- Sleep apnea is a potentially lethal condition where the patient stops breathing during sleep. The three types are central, obstructive, and mixed.
- Apnea is defined as a cessation of airflow for at least ten seconds.
- Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30% reduction in thoracoabdominal movement or airflow with at least 4% oxygen desaturations.

3.2.3 Parasomnia

- Parasomnia is a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions may include sleepwalking, sleep terrors, and rapid eye movement (REM) sleep behavior disorders.
- Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG studies.

3.2.4 Periodic Limb Movement Disorder (PLMD)

PLMD is an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding daytime sleepiness.

3.2.5 Chronic Insomnia

At least one of the following conditions must be met.

- Etiology is unknown
- Diagnosis is uncertain.
- Sleep-related breathing disorder or periodic limb movement disorder is suspected.
- A patient is refractory to treatment.
- Violent behaviors are comorbid.
- Circadian dysrhythmias complicate the clinical picture.

3.2.6 Snoring

At least one of the following conditions must be met.

- Disturbed sleep patterns
- Excessive daytime sleepiness
- Unexplained awake hypercapnia
- Apneic breathing
- Cognitive problems
- Excessive fatigue

Sleep Study and Polysomnography Services Criteria Updated 01/14

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Recipients under 21 Years of Age.

4.1 General Criteria

Procedures, products, and services are not covered when one of the following apply:

- a. The recipient does not meet the eligibility requirements listed in Section 2.0.
- b. The recipient does not meet the medical necessity criteria listed in Section 3.0.
- c. The procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service.
- d. The procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Noncovered Criteria

- a. Sleep studies and polysomnography are not covered when the service is an unattended home study.
- b. Sleep studies and polysomnography are not considered medically necessary for the following indications:
 - Impotence.
 - Chronic insomnia, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.
 - Snoring, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Recipients under 21 Years of Age.

5.1 Prior Approval

Prior approval is required.

5.2 Previous Testing

Previous testing performed by the attending physician, to the extent the results are still pertinent, should not be duplicated.

5.3 General Requirements

Sleep studies and polysomnography must include recording, interpretation, and reporting.

5.4 Polysomnography Requirements

For a study to be reported as polysomnography, sleep must be recorded and staged. Sleep staging includes but is not limited to the following:

- a. 1 to 4-lead electroencephalogram (EEG)
- b. Electro-oculogram (EOG)
- c. Submental electromyogram (EMG)
- d. Electrocardiogram (EKG)

Sleep Study and Polysomnography Services Criteria Updated 01/14

5.4 Polysomnography Requirements (continued)

- e. Airflow, ventilation, and respiratory effort
- f. Oximetry and/or CO₂ measurements
- g. Extremity muscle activity
- h. Extended EEG monitoring
- i. Gastroesophageal reflux
- j. Continuous blood pressure monitoring
- k. Snoring
- l. Body positions

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this criteria, providers must:

- a. Meet Kansas Medicaid qualifications for participation.
- b. Be currently enrolled in Medicaid.
- c. Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Recipients under 21 Years of Age.

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the HIPAA and record retention requirements.

Sleep Study and Polysomnography Services Criteria Updated 01/14

8.0 Billing Information

CPT codes, descriptors, and other data only are copyright 2014 [American Medical Association](#). All rights reserved.

8.1 Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

ICD-9-CM Diagnosis Code	Description
278.01	Morbid obesity
278.8	Other hyperalimentation
307.47	Other dysfunctions of sleep states or arousal from sleep
307.48	Repetitive intrusions of sleep
327.23	Obstructive sleep apnea
327.51	Periodic limb movement disorder
345.80	Other forms of epilepsy without mention of intractable epilepsy
345.81	Other forms of epilepsy with intractable epilepsy
347.00	Narcolepsy without cataplexy
347.01	Narcolepsy with cataplexy
347.10	Narcolepsy in conditions classified elsewhere without cataplexy
347.11	Narcolepsy in conditions classified elsewhere with cataplexy
780.09	Alterations of consciousness, other
780.51	Insomnia with sleep apnea
780.53	Hypersomnia with sleep apnea
780.54	Other hypersomnia
780.55	Disruptions of 24-hour sleep–wake cycle
780.56	Dysfunctions associated with sleep stages or arousal from sleep
780.57	Other and unspecified sleep apnea
780.58	Sleep-related movement disorder
780.59	Other sleep disturbances
786.09	Dyspnea and respiratory abnormality, other
799.01	Asphyxia
799.02	Hypoxemia

8.2 Billing Codes

Providers are required to select the most specific billing code that accurately describes the service(s) provided. Refer to the *CPT*[®] codebook for complete descriptions.

95782	95783	95805	95807	95808	95810	95811
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8.3 Modifiers

Providers are required to follow applicable modifier guidelines.

Sleep Study and Polysomnography Services Criteria Updated 01/14

8.4 Billing Units

- a. Polysomnography and sleep studies may be billed as a complete procedure or as professional and technical components.
 - Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.
 - The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.
 - The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that should be billed. The complete procedure should not be billed with two dates of services.
 - If components are billed, the technical and the professional components should be billed with the date the service was rendered as the date of service.
- b. Separate reimbursement is not allowed for the following procedures on the same date of service by the same or different provider.
 - *CPT* codes 93224 through 93272 with *CPT* codes 95805 through 95811
 - *CPT* codes 94760 and 94761 with *CPT* codes 95805 through 95811
 - *CPT* code 94772 with *CPT* codes 95805 through 95806)
 - *CPT* code 94660 with *CPT* code 95811
 - *CPT* codes 95812 through 95827 with *CPT* codes 95808 through 95811
 - *CPT* code 92516 with *CPT* codes 95808 through 95811

8.5 Place of Service

- a. Inpatient hospital
- b. Outpatient hospital
- c. Physician's office