KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Local Education Agency

Updated 12.2016
PART II
LOCAL EDUCATION AGENCY 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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PART II
LOCAL EDUCATION AGENCY FEE-FOR-SERVICE PROVIDER MANUAL

Updated 06/16

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to local education agency (LEA) providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection explains the method of billing applicable to LEA services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of LEA services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

**HIPAA Compliance**
As a participant in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by 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.

The Kansas Medicaid Fraud Control Act (K.S.A. 2004 Supp. 21-3844 to 21-3855) requires that providers keep records for five years from the date of payment or, if the claim does not pay, the date when the provider submitted the claim.

LEAs must verify that none of the practitioners providing services have been terminated, suspended, or barred from the Medicaid or Medicare program.

The following websites can be used for screening terminated, suspended, and barred providers.
- [System for Award Management](https://www.sam.gov) (SAM) – Click the Search Records button.
LEA providers must submit claims electronically. Refer to your *Paperless Claim Manual* for instructions.

Call the Electronic Media Services department at 1-800-472-6481 for the method that best fits your needs. Full training and support are provided.
Place of Service Codes
The only allowable place of service values are 03-school or 12-home.

Nursing Attendant Codes
The only allowable place of service values are 03-school or 12-home.
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 08/08

LEA services are exempt from copayment requirements.
BENEFITS AND LIMITATIONS

8300. BENEFIT PLAN  Updated 10/13

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.
BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 06/16

Medicaid reimburses LEAs for medically necessary services for the child to receive a free and appropriate public education, as documented on the child's individualized educational plan (IEP). Payment is made to LEAs approved by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) for services provided through KMAP as listed in Appendix I.

Only covered medically necessary services identified on the child’s IEP will be eligible for reimbursement. A yearly KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) screening service performed by an LEA provider does not require an IEP. LEAs are required to provide documentation of findings identified during an annual KBH-EPSDT screen to the beneficiary’s primary medical provider. KBH-EPSDT screening CPT® codes performed more frequently than once per calendar year must be included in an IEP and meet medical necessity. Refer to the KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Provider Manual for further information regarding EPSDT screening requirements.

Ongoing services can be addressed on the individual health plan (IHP), behavior intervention plan (BIP), and/or assisted technology plan. These plans must be identified in the IEP as well as attached to it.

Providers of Medicaid-reimbursable services in an LEA must have appropriate credentials as described in the Medicaid State Plan and as required by the Kansas State Department of Education (KSDE). Professionals are expected to supervise the work of same-type paraprofessionals and confine the scope of practice to the usual and customary for their profession/paraprofession.

Services delivered by an LEA do not require a referral from the child's Medicaid managed care provider. A physician’s order/authorization for the services being billed must be obtained prior to submitting claims to Medicaid. The only exception includes the provision of evaluations which may be completed without a physician order/authorization. A Release of Information must be on file before a Physician Authorization can be requested. All medical services must be authorized by a physician, doctor of osteopathic medicine, naturopath, physician’s assistant, or nurse practitioner. This includes recommendations for specific programs, providers, methods, settings, frequency, and intensity of services. The Physician Authorization form must specify which services the physician is certifying for each student. Backdating is not allowed.

Services must be medically necessary and may be habilitative or rehabilitative for maximum reduction of disability and restoration to the best possible functional level. Services which are educationally necessary but not medically necessary will not be covered. Services must be approved and provided by an Early Childhood Intervention (ECI), Head Start, or LEA program.
An evaluation for physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) is not Medicaid-reimbursable unless an IEP is developed which includes a recommendation for ongoing services in that same therapy type. If the assessment does not reveal “medical necessity” for the services, the assessment cannot be billed. IDEA-driven evaluations are Medicaid-reimbursable only for students determined to have a disability.

In the case that an evaluation for a child is conducted across a time period involving more than one day (for example, 15 minutes carried out on Day 1, 15 minutes on Day 2, etc.), the practitioner should not submit a bill until the date of completion for that evaluation. Each of the service codes may be billed once per evaluation per child on the date of completion of that evaluation. Multiple bills must not be submitted for the same evaluation for the same child, even if it is conducted over the course of more than one day.

Therapy should be provided only for individuals with a Physician Treatment Plan, an IEP, or an IFSP. A physician’s order/authorization is required for physical, speech, occupational, and other therapies. Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit. If a student is receiving therapies outside of the school setting, documentation within the IEP must include the details of therapy and clearly reflect there is not duplication of service. Coordination of care must be maintained.

OT services must be provided by a registered occupational therapist or by a certified occupational therapy assistant working under the supervision of a registered occupational therapist.

PT services must be provided by a registered physical therapist or by a certified physical therapy assistant working under the supervision of a registered physical therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered occupational or physical therapist initializing each treatment note written by the certified occupational or physical therapy assistant, or the registered occupational or physical therapist writing “Treatment was supervised” followed by his or her signature. At least once every sixth visit by the occupational or physical therapist assistant or at least once every 30 calendar days, whichever comes first, the registered occupational or physical therapist must visit the patient. The supervising therapist must review and countersign the assistant’s documentation within five days of the information being recorded.

In order for a make-up therapy session to be Medicaid-reimbursable, it must be consistent with the order/authorization and must:

- Be a service documented in the IEP
- Occur within the week of any missed visit
- Be documented
  
  Note: Session notes must be kept for each session including make-up sessions.
- Be provided by a qualified Medicaid provider
- Fit with the desired treatment outcome

Cotreatment consists of more than one professional providing treatment at the same time. Therapists or therapist assistants working together as a “team” to treat one or more individuals **cannot** bill separately for the same or different services provided at the same time to the same individual. For cotreatments, only one CPT code may be billed per session (untimed CPT codes) or per unit (timed CPT codes).
Either one therapist can bill for the entire service or the therapists can divide the service units (if applicable) where an occupational and physical therapist (timed CPT code) both provide services to one individual at the same time. Only one discipline per session may be billed where a SLP (untimed CPT code) and an occupational or physical therapist (timed CPT code) both provide services to one individual at the same time.

To calculate billing units, count the total number of billable minutes for the calendar day for the student and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven. They are converted to 0 units of service if they are seven minutes or less.

**Billing Therapy Services**

<table>
<thead>
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<th>Units</th>
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<tbody>
<tr>
<td>0-7</td>
<td>0</td>
</tr>
<tr>
<td>8-22</td>
<td>1</td>
</tr>
<tr>
<td>23-37</td>
<td>2</td>
</tr>
<tr>
<td>38-52</td>
<td>3</td>
</tr>
<tr>
<td>53-67</td>
<td>4</td>
</tr>
<tr>
<td>68-82</td>
<td>5</td>
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</tbody>
</table>

The time (minutes) for all nursing services delivered to a student during a calendar day must be added together before they are converted to units of service.

Nursing attendant care services may be billed by LEAs for students with those services in their IEPs. Specific services allowed include S9123 (by RN, per hour) and S9124 (by LPN, per hour).

The LEA may use its own employees or contracted staff from another agency to provide these services.

**Billing Nursing Attendant Care**

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0 billable</td>
</tr>
<tr>
<td>6-11</td>
<td>0.1 billable</td>
</tr>
<tr>
<td>12-17</td>
<td>0.2 billable</td>
</tr>
<tr>
<td>18-23</td>
<td>0.3 billable</td>
</tr>
<tr>
<td>24-29</td>
<td>0.4 billable</td>
</tr>
<tr>
<td>30-35</td>
<td>0.5 billable</td>
</tr>
<tr>
<td>36-41</td>
<td>0.6 billable</td>
</tr>
<tr>
<td>42-47</td>
<td>0.7 billable</td>
</tr>
<tr>
<td>48-53</td>
<td>0.8 billable</td>
</tr>
<tr>
<td>54-59</td>
<td>0.9 billable</td>
</tr>
<tr>
<td>60-65</td>
<td>1 billable</td>
</tr>
</tbody>
</table>

A physician-selected ICD diagnosis code must identify the condition for which the beneficiary is receiving services. For dates of service prior to October 1, 2015, an appropriate diagnosis code would be 783.40. For dates of service on and after October 1, 2015, an appropriate diagnosis code would be R62.50.
Social work services must be provided by or under the direction of a licensed social worker in accordance with 42 CFR 440.60 (a). The services must be provided by a school social worker who holds a current and valid license issued by the Behavioral Sciences Regulatory Board, at the licensed master social worker (LMSW), licensed specialist clinical social worker (LSCSW), or temporary licensed master’s social worker (TLMSW or LMSWT) level. (This criteria mirrors current KSDE requirements.)

Psychological services must be provided by or under the direction of a licensed psychologist in accordance with 42 CFR 440.60 (a). The psychologist must be licensed by the Behavioral Sciences Regulatory Board and/or licensed and endorsed by KSDE as a “school psychologist”. (This criteria mirrors current KSDE requirements.)

Social work and psychology services limitations include the following:
- Individual counseling reimbursement is limited to a combined total of two hours (four units) per calendar week.
- Group counseling reimbursement is limited to a combined total of one hour (two units) per calendar week.
- Psychological testing reimbursement is limited to a total of three hours per school year.
- Reimbursement is one hour equals one unit. For those individuals that cannot participate in a full hour of testing, the testing can be broken out into 15-minute increments as follows:
  - 0-5 minutes = 0 units
  - 6-15 minutes = .25 units
  - 16-30 minutes = .5 units
  - 31-45 minutes = .75 units
  - 46-60 minutes = 1 unit
- Development testing reimbursement is limited to one session per school year.

Documentation of all services performed is required and must include:
- Date, time, and detailed description of each intervention/service delivered and by whom (name, designation of profession or paraprofession)
- Assessment and response to intervention/service using objective measures allowing the reader to determine progress toward goal(s)
- Progress toward achieving individualized long- and short-term goals

Documentation of services found to be conflicting with other documentation or schedules will result in full recoupment of involved services. Examples include but are not limited to:
- Performer is documenting the delivery of a direct service at the same or overlapping time for two beneficiaries.
- Performer is documenting the delivery of a service at the same or overlapping time as the performer is entering documentation into an LEA record.
- Performer is documenting the delivery of service prior to or during the reported treatment time.
- Beneficiary is documented as receiving two separate services at the same time or at overlapping times. Exception: Appropriately billed cotreatment.
- Performer is documenting the delivery of a service when the student is reportedly absent.
- Performer is documenting the delivery of a service when school is not in session.
Not all services provided by LEAs are billable. Examples include but are not limited to:

- Preparation for and attendance of IEP meetings
- Telephone calls/conferences/contacts
- Travel time
- Time spent in observation unless the description of the code specifies the allowance
- Missed services (i.e. student refusal, absent participation)
- Delegated services performed by an unlicensed or uncertified individual
- Nursing services for which a specialized skill is not required to perform
- Nursing services for which the documentation does not support delivery of specialized skills
- Time spent by clinicians in supervision or consultation
- Time spent for documentation/report writing unless the description of the code specifies the allowance
- Services involving an individual who has been excluded from participation in federally funded programs

Services provided by LEA providers are by law at no cost to the family. Because the services are at no charge to the family, most insurance companies consider these services as not covered by their policies. Therefore, KMAP does not require LEA providers to seek payment from private insurance companies to be eligible to receive Medicaid reimbursement. Similarly, KMAP will not seek reimbursement from the insurance companies.

However, KMAP does require all Medicaid providers to report insurance resources of which they become aware. This reporting assists KMAP in billing for other services that the other insurance company covers, such as hospitalization.

This policy does not prevent LEA providers from billing and collecting from insurance companies which do cover these services. If a provider anticipates that an insurance company will cover the services and the parents give the provider permission to bill the insurance, this private resource should be accessed prior to accessing taxpayer-funded Medicaid.
The following codes represent an all-inclusive list of LEA services billable to KMAP. Procedures not listed here are considered noncovered.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website
- Information from the secure website under Pricing and Limitations

A chart has been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table is available on both the public and secure websites. It can be accessed from the Reference Codes link under the Interactive Tools heading on the Provider page and Pricing and Limitations on the secure portion. Information is also available on the American Medical Association website.

| Category                      | Codes       
|-------------------------------|-------------
| AUDIOLOGY                     | 92551 92552 92553 92555 92556 92557 92567 |
| KBH-EPSDT CODES               | 99173 99202 99203 99204 99205 99213 99214 99215 92551 99383 99384 99385 99393 99394 99395 |
| NURSING                       | S9123 S9124 T1001 T1002 T1003 |
| OCC/PHYSICAL/SPEECH THERAPY   | 92507 92508 92521 92522 92523 92524 92524 97001 97002 97003 97004 97110 97112 97113 97116 97150 97161 97162 97163 97164 97165 97166 97167 97168 97530 97532 97533 97535 97537 |
| PSYCHOLOGY THERAPY            | 96101 96110 96127 99402 99411 |
| SOCIAL WORK THERAPY           | 96110 96127 99402 99441 |