KANSAS MEDICAL ASSISTANCE PROGRAM

Money Follows the Person

Updated 09/2011
# PART II
## MONEY FOLLOWS THE PERSON PROVIDER MANUAL

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>MFP Limitations &amp; Housing Options</td>
<td>i-1</td>
</tr>
<tr>
<td>MFP Enrollment</td>
<td>i-1</td>
</tr>
<tr>
<td><strong>BILLING INSTRUCTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>7000</td>
<td>7-1</td>
</tr>
<tr>
<td>MFP Billing Instructions</td>
<td>7-1</td>
</tr>
<tr>
<td>Submission of Claim</td>
<td>7-1</td>
</tr>
<tr>
<td>7010</td>
<td>7-2</td>
</tr>
<tr>
<td>MFP Specific Billing Information</td>
<td>7-2</td>
</tr>
<tr>
<td><strong>BENEFITS AND LIMITATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>8400</td>
<td>8-1</td>
</tr>
<tr>
<td>General Benefits and Limitations</td>
<td>8-1</td>
</tr>
<tr>
<td>MFP FE Assistive Technology</td>
<td>8-3</td>
</tr>
<tr>
<td>MFP FE Comprehensive Support</td>
<td>8-5</td>
</tr>
<tr>
<td>MFP FE Sleep Cycle Support</td>
<td>8-8</td>
</tr>
<tr>
<td>MFP MR/DD Temporary Respite Care</td>
<td>8-10</td>
</tr>
<tr>
<td>MFP PD Assistive Services</td>
<td>8-12</td>
</tr>
<tr>
<td>MFP PD Personal Services</td>
<td>8-14</td>
</tr>
<tr>
<td>MFP TBI Assistive Services</td>
<td>8-17</td>
</tr>
<tr>
<td>MFP TBI Personal Services</td>
<td>8-19</td>
</tr>
<tr>
<td><strong>FORMS</strong></td>
<td></td>
</tr>
<tr>
<td>All forms pertaining to this provider manual can be found on the public website at <a href="https://www.kmap-state-ks.us/Public/forms.asp">https://www.kmap-state-ks.us/Public/forms.asp</a> and on the secure website at <a href="https://www.kmap-state-ks.us/provider/security/logon.asp">https://www.kmap-state-ks.us/provider/security/logon.asp</a> under Pricing and Limitations.</td>
<td></td>
</tr>
</tbody>
</table>

*CPT codes, descriptors, and other data only are copyright 2011 American Medical Association (or such other date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply. Information on the American Medical Association is available at [http://www.ama-assn.org](http://www.ama-assn.org).*
INTRODUCTION TO THE MONEY FOLLOWS THE PERSON PROGRAM

Updated 09/11

The Money Follows the Person (MFP) demonstration program not only allows residents to receive Home and Community Based Services (HCBS) in the community but also enhanced services which allow for payment of utility deposits and reasonable expenses to re-establish a residence. MFP enhanced services will make it possible for the resident to return to the community. Beneficiaries can receive up to 365 days of MFP funding before their case is transitioned to the 1915 C HCBS waivers. The four populations that will be served by this grant are Frail Elderly (FE), Physical Disability (PD), Traumatic Brain Injury (TBI), and Mental Retardation/Developmentally Disabled (MRDD). In Kansas, this grant will serve a total of 963 beneficiaries.

To be eligible for this program, a beneficiary must meet the following criteria:

- Be a current resident of a nursing facility (NF) or intermediate care facility for mental retardation (ICF/MR) with a 90-day continuous stay
  
  Note: The 90 days cannot include Medicare skilled rehabilitation days.
  
  Note: Prior to May 27, 2010, a six-month continuous stay was required.

- Be Medicaid-eligible 30 days prior to receiving MFP services
- Meet the functional eligibility for waivered services
- Have an interest in transitioning back into the community

All MFP services, with the exception of targeted case management (TCM), oral health services, and community bridge building, require prior authorization (PA) through the plan of care (POC) process.

Oral health services are available to adults 21 years of age and older who are enrolled in the MFP program. Refer to Exhibit D in the Dental Provider Manual for services available for HCBS MRDD, TBI, and PD adult beneficiaries.

Services Offered Under the MFP Demonstration

- HCBS waivered services specific to the beneficiary
- Transition services – up to $2500
- Home modification/assistive technology
  
  Note: Authorized services will not count toward $7500 lifetime cap.
- Community bridge building
- Transition coordination services
- TCM service (see below)
- Therapeutic support (MRDD and TBI only)
- MRDD Specialized Medical Care
- Financial Management Services (FMS)

To access program specific service information, reference this manual for the following:

- MFP FE Assistive Technology, Comprehensive Support, and Sleep Cycle Support
- MFP MRDD Temporary Respite Care
- MFP PD Assistive Services and Personal Services (Self-Directed and Agency-Directed)
- MFP TBI Assistive Services and Personal Services (Self-Directed and Agency-Directed)

For all other program specific service information, reference the applicable HCBS provider manual.
INTRODUCTION TO THE MONEY FOLLOWS THE PERSON PROGRAM

Updated 09/11

Housing Options for MFP Beneficiaries
- Home owned or leased by the beneficiary or beneficiary’s relative
- Leased apartment or home, lockable egress, includes living, sleeping, and cooking areas
- Community-based residence for no more than four unrelated individuals (MRDD only)
- Assisted living facilities for the FE and PD populations only

Note: The MFP demonstration grant has specific criteria for housing options. Beneficiaries cannot reside in residential care facilities, homes plus, or boarding care homes. Additionally, TBI and MRDD beneficiaries cannot reside in assisted living facilities.

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

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.
TCM for MFP

- TCM for MFP does not require PA through the POC process.
- TCM for MFP must be billed with a modifier U7. MFP TCM is billed under T1017-U7.
- The provider must track all pretransition TCM for MFP services as they occur. The services must not be billed until the beneficiary transitions into the community. Once the beneficiary has transitioned, the provider can bill for all the pretransition TCM for MFP services at one time using the date of transition as the billable date for these services. The provider must use the billing code T1017-U7.
- TCM is subject to current state plan case management regulations. However, there is an additional limitation override for MFP which is detailed on the following page. All other current TCM requirements remain.

Limitations

There is a maximum allowable number of units per beneficiary within each waiver used for MFP per calendar year.

- MFP FE: Allow 800 units MFP FE TCM per calendar year
- MFP MRDD: Allow 240 units MFP DD TCM per calendar year
- MFP TBI: Allow 640 units of MFP TBI TCM per calendar year
- MFP PD: Allow 480 units of MFP PD TCM per calendar year

This limitation may be waived with PA by the Kansas Department on Aging (KDOA), the Kansas Department of Social and Rehabilitation Services (SRS) Health Care Policy, Community Supports and Services for FE, MRDD, PD and TBI.

For all other information regarding TCM, refer to the existing TCM manual for the appropriate waiver.
Introduction to the CMS-1500 Claim Form
Providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services provided under KMAP. Any CMS-1500 claim form not submitted on the red claim form will be returned to the provider. An example of the CMS-1500 claim form is on the public and secure websites at:

- https://www.kmap-state-ks.us/Public/forms.asp

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.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the General Billing Provider Manual.

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
**Client Obligation**

If a targeted case manager has assigned a client obligation to a particular provider and informed this 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 POC and cannot overlap.

Example:

An electronic POC has two detail lines items: 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 the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC 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, MFP services approved on a POC and provided the same day a beneficiary is hospitalized or in a NF may be allowed. Situations are limited to:

- MFP services provided the date of admission, if provided prior to the beneficiary being admitted
- MFP services provided the date of discharge, if provided following the beneficiary’s discharge
- Emergency response services
- MFP Targeted Case Management (not a POC service) provided 30 days prior to discharge
MFP General Documentation Requirements

- Written documentation is required for services provided and billed to KMAP.
- Documentation must be generated at the time of purchase. Generating documentation after-the-fact is not acceptable.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.
- Time must be totaled by actual minutes and hours worked. Billing staff may round the total to the nearest quarter hour at the end of a billing cycle.
- For a postpayment review, reimbursement will be recouped if documentation is not complete.
- Sample forms for documenting services are on the public and secure websites at:
  - https://www.kmap-state-ks.us/Public/forms.asp
  Use of these specific forms is not required, but they may be duplicated for use.

MFP Signature Limitations

In all situations, the expectation is that the beneficiary provides oversight and accountability for people providing services for them. Signature options are provided in recognition that a beneficiary's limitations make it necessary that they be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided. The individual providing the services cannot sign the time sheet on behalf of the beneficiary.

Each time sheet must contain the signature of the beneficiary or designated signatory verifying that the beneficiary received the services and that the time recorded on the time sheet is accurate. The approved signing options include:

- 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 time sheets without a legitimate reason should be advised that the attendant's time may not be paid or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned time sheets are a matter for the billing provider to address with the targeted case manager.
MFP Electronic Documentation
Documention must at a minimum include the following:
- Identify the waiver service being provided
- Identify the beneficiary receiving the service(s)
- Identify the attendant providing the service(s)
- Date of service
- The start time of the service, include AM/PM or use 2400 clock hours
- The stop time of the service, include AM/PM or use 2400 clock hours
- Identify duties performed during each visit
- The beneficiary’s signature authorizing the utilization 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.
Assistive Technology (AT) consists of either one of the following:

- Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab bars, bath benches, toilet risers, and lift chairs
- Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings

Specific Limitations

- AT is limited to the beneficiary’s assessed level of service need, as specified in the beneficiary’s POC, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.
- All AT purchases require PA from KDOA.
- This service must be cost-effective and appropriate to the beneficiary’s needs.
- This service is limited to a lifetime maximum of $7,500.
- AT funded by other waiver programs is calculated into the lifetime maximum.
- Payment is for the item or modification and does not include administrative costs.
- Repairs or maintenance are not allowed for home modifications or assistive items.
- Home modification includes only those adaptations that are necessary to accommodate the mobility of the beneficiary.
- Replacements and duplicate items are not covered for the first twelve months after the purchase date of the item.
- For home modifications to be authorized in a home not owned by the beneficiary, the owner/landlord must agree, in writing, to maintain the modifications for the time period in which the MFP beneficiary resides there.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- External modifications (such as, porches, decks, and landings) will only be allowed to the extent required to complete the approved request.
- Home accessibility adaptations cannot be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- If Medicare covers an AT item but denies authorization, MFP will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

Specific Documentation Requirements

Provider must maintain a copy of the receipt identifying that the service was provided. The receipt must include:

- Name of the provider
- Identification of item or technology being provided
- Date of service (MM/DD/YY)
- Amount of purchase
- Beneficiary’s first and last name and signature
MFP FE ASSISTIVE TECHNOLOGY
Specific Enrollment Criteria
Any business, agency, or company that furnishes AT items or services is eligible to enroll. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

Specific Reimbursement
Enter diagnosis code 780.99 in Field 21 on the CMS-1500 claim form.
Enter procedure code T2029 in Field 24D of the CMS-1500 claim form.
One unit equals one purchase.
MFP FE COMPREHENSIVE SUPPORT
Comprehensive Support is one-on-one, nonmedical assistance, observation, and supervision provided for a cognitively impaired adult to meet his or her health and welfare needs. The provision of Comprehensive Support does not entail hands-on nursing care. The primary focus is supportive supervision.

The support worker is present to supervise the beneficiary and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example, reading mail, books and magazines or writing letters) can also be provided.

Comprehensive Support can be provided in the beneficiary’s choice of housing, including temporary arrangements.

This service shall not duplicate other waiver services.

There are two methods of providing Comprehensive Support, provider-directed and self-directed. Beneficiaries are given the option to self-direct their Comprehensive Support. A combination of service providers, either provider-directed and/or self-directed, can be used to meet the approved POC.

The beneficiary’s representative is given the option to self-direct the beneficiary’s Comprehensive Support. He or she may be an individual acting on behalf of the beneficiary, a person authorized as an activated durable power of attorney (DPOA) for health care decisions, a guardian, or a conservator. If the representative chooses to self-direct Comprehensive Support, he or she is responsible for making choices about Comprehensive Support, including referring for hire, supervising and terminating the employment of support workers, understanding the impact of those choices, and assuming responsibility for the results of those choices.

Specific Limitations
- Comprehensive Support is limited to the beneficiary’s assessed level of service need, as specified in the beneficiary’s POC, not to exceed 12 hours per 24-hour time period, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Support workers must be 18 years of age.
- Comprehensive Support is limited to a maximum of 48 units (12 hours) a day to occur during the beneficiary’s normal waking hours. Comprehensive Support in combination with other MFP FE waiver services cannot exceed 24 hours a day.
- A beneficiary who has a guardian and/or conservator cannot choose to self-direct his or her Comprehensive Support; however, a guardian and/or conservator can make that choice on the beneficiary’s behalf.
- Under no circumstances shall a beneficiary’s spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a beneficiary be paid to provide Comprehensive Support for the beneficiary.
MFP FE COMPREHENSIVE SUPPORT

Specific Limitations (continued)

- For a beneficiary self-directing, the targeted case manager and the beneficiary or his or her representative will use discretion in determining if the selected support worker can perform the needed services.
- Beneficiaries residing in an assisted living facility must have this service provided by a licensed Home Health Agency (HHA) and are not eligible to self-direct this service.
- An individual providing Comprehensive Support must have a permanent residence separate and apart from the beneficiary.
- This service is limited to those beneficiaries who live alone or do not have a regular caretaker for extended periods of time.
- Comprehensive Support cannot be provided at the same time as the MFP FE Attendant Care Services or MFP FE Sleep Cycle Support.
- This service will not be paid while the beneficiary is hospitalized, in a nursing home, or in any other location where he or she is unable to receive the service.

Specific Documentation Requirements

Documentation must include the following:

- Identification of the waiver service being provided (Comprehensive Support)
- Initials of both beneficiary and support worker for each visit if using a log which covers more than one day
- Beneficiary’s first and last name and signature, on each page of documentation
- Support worker’s name and signature, on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

PROVIDER-DIRECTED COMPREHENSIVE SUPPORT Enrollment

- Medicare-certified or KDHE-licensed HHAs
- Centers for independent living (CILs)
- County health departments
- Entities not licensed by SRS, KDOA, or KDHE

Note: These entities must provide the following documentation:

  - A certified copy of its Articles of Incorporation or Articles of Organization
  Note: If a corporation or limited liability company is organized in a jurisdiction outside the State of Kansas, the entity must provide written proof that it is authorized to do business in the State of Kansas.
  - Written proof of liability insurance or surety bond

Note: Providers of payroll agent services for the self-directed care option must be a CIL, HHA or a company owned or controlled by a CIL or HHA.

SELF-DIRECTED COMPREHENSIVE SUPPORT Enrollment

To enroll, providers must meet the provider requirements for FMS. Self-directed support workers must be referred to the enrolled FMS provider of the beneficiary’s choice for completion of required human resources and payroll documentation.
8400. BENEFITS AND LIMITATIONS  Updated 09/11

MFP FE COMPREHENSIVE SUPPORT
Specific Reimbursement
One unit equals 15 minutes.
Enter code 780.99 in Field 21 on the CMS-1500 claim form.

Self-Directed Comprehensive Support
Enter the authorized code with modifier, S5135UD, in Field 24D of the CMS-1500 claim form. Maximum unit cost equals $2.71 per unit of self-directed service.

Provider-Directed Comprehensive Support
Enter code S5135 in Field 24D of the CMS-1500 claim form. Maximum unit cost equals $3.38 per unit of provider-directed service.

Although for billing purposes the system POC is authorized on a monthly basis, the total hours for a beneficiary cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and Notice of Action.
MFP FE SLEEP CYCLE SUPPORT
This service provides non-nursing physical assistance and/or supervision during the beneficiary’s normal sleeping hours in the beneficiary’s place of residence, excluding adult care homes.

This service includes:
- Physical assistance or supervision with toileting, transferring and mobility
- Prompting and reminding of medication

This service shall not duplicate other waiver services.

The support worker can sleep but must awaken as needed to provide assistance as identified in the beneficiary’s service plan. The support worker must provide the beneficiary a mechanism to gain his or her attention or awaken him or her at any time. The support worker must be ready to call a physician, hospital or other medical personnel should an emergency arise. The support worker must submit a report to the targeted case manager within the first business day following any emergency response provided to the beneficiary.

Sleep Cycle Support is a self-directed service. The beneficiary or representative is responsible for making choices about Sleep Cycle Support, including referring for hire, supervising and terminating the employment of support workers, understanding the impact of those choices, and assuming responsibilities for the results of those choices.

Specific Limitations
- Sleep Cycle Support is limited to the beneficiary’s assessed level of service need, as specified in the beneficiary’s POC, not to exceed 12 hours per 24-hour time period, subject to an exception process established by the State. All beneficiaries are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Support workers must be 18 years of age or older.
- Period of service must be at least six hours in length but cannot exceed a 12-hour period of time.
- Only one unit is allowed within a 24-hour period of time.
- Sleep Cycle Support in combination with other MFP FE waiver services cannot exceed 24 hours per day.
- Under no circumstances shall a beneficiary’s spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a beneficiary be paid to provide Sleep Cycle Support for the beneficiary.
- Beneficiaries residing in an assisted living facility are not eligible for this service.
- The support worker must have a permanent residence separate and apart from the beneficiary.
- The targeted case manager and the beneficiary or his or her representative will use discretion in determining if the selected support worker can perform the needed services.
- This service shall not be paid while the beneficiary is hospitalized, in a nursing home, or in any other situation where he or she is unavailable to receive the service.
MFP FE SLEEP CYCLE SUPPORT

Specific Documentation Requirements

Documentation must include the following:

- Identification of the waiver service being provided
- Beneficiary’s and caregiver’s initial each visit if using a time sheet which covers more than one day
- Beneficiary’s first and last name and signature, at a minimum each week
- Caregiver’s name and signature, at a minimum each week
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

Specific Enrollment

To enroll, providers must meet the provider requirements for FMS. Self-directed support workers must be referred to the enrolled FMS provider of the beneficiary’s choice for completion of required human resources and payroll documentation.

Enrolled providers act as payroll agents on behalf of beneficiaries. Self-directed support workers must enroll through one of the following Medicaid providers:

- KDHE-licensed HHAs
- Medicare-certified HHAs
- CILs, recognized by SRS
- A company owned or controlled by a HHA or CIL

Specific Reimbursement

One unit equals six to twelve hours. Only one unit is allowed within a 24-hour period of time.

Maximum unit cost equals $22.44.

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

Enter procedure code T2025 in Field 24D of the CMS-1500 claim form.

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery, to provide consistency with other Medicaid services such as home health aide visits, and to meet beneficiary preferences in providers and service delivery methods. Beneficiary health and safety and program cost effectiveness will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the plan regardless of the length of time needed to deliver the service.
MFP MRDD TEMPORARY RESPITE CARE
Respite Care is temporary care provided to a beneficiary to provide relief for the beneficiary's family member who serves as an unpaid primary caregiver. Respite is necessary for families who provide constant care for beneficiaries. It allows family members to receive periods of relief for vacations, holidays, and scheduled periods of time off.

Overnight respite may be provided in the following locations and will allow for staff to sleep:
- Beneficiary’s family home or place of residence
- Licensed foster home
- Facility approved by KDHE or SRS which is not a private residence
- Licensed respite care facility/home

Specific Limitations
- MFP MRDD Respite Care is available to Medicaid beneficiaries who:
  - Are five years of age or older
  - Are mentally retarded or otherwise developmentally disabled
  - Meet the criteria for ICF/MR level of care as determined by ICF/MR (MFP MRDD) screening
  - Choose to receive MFP MRDD rather than ICF/MR services
  - Have a family member who serves as the primary caregiver who is not paid to provide any MFP MRDD program service for the beneficiary
- MFP MRDD Respite Care is available to minor children, five to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- MFP MRDD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Room and board costs are excluded in the cost of any MFP MRDD waiver services except overnight facility-based respite.
- Respite Care can only be provided to beneficiaries living with a person immediately related to the beneficiary. Immediate family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any stepfamily relationships.
- Respite Care cannot be provided by a beneficiary’s spouse or by a parent of a beneficiary who is a minor child under 18 years of age.
- Beneficiaries receiving Respite Care cannot also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.
- A beneficiary can receive Respite Services from more than one worker, but no more than one worker can be paid for services at any given time of day. A respite care provider cannot be paid to provide services to more than one beneficiary at any given time of day.
MFP MRDD TEMPORARY RESPITE CARE

Temporary Respite

- Temporary Respite is limited to 330 hours or 1320 units, per beneficiary, per calendar year.
- Temporary Respite is provided in planned or emergency 15-minute segments and may include payment during the beneficiary’s sleep time limited to a maximum of two hours before and after the beneficiary is scheduled to wake up or go to bed.

Specific Provider Requirements

Providers of Respite Care must be affiliated with the Community Developmental Disability Organizations (CDDO) for the area where they operate. Providers of overnight facility-based Respite Care for minor children must be licensed by SRS or KDHE. Adult respite providers must be licensed by SRS Disability and Behavioral Health Services.

A self-direct option may be chosen for Respite Care by the beneficiary. If the beneficiary is not capable of providing self direction, the beneficiary’s guardian or someone acting on his or her behalf can choose.

Specific Documentation Requirements

Documentation, at a minimum, must include the following:

- Name of service being provided
- Beneficiary’s first and last (or responsible party’s) name and signature if self-directing
- Caregiver’s name and signature
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

Specific Reimbursement

Enter procedure code H0045 in Field 24D on the CMS-1500 claim form. One unit equals one day (H0045).
MFP PD ASSISTIVE SERVICES
Assistive Services are those services which meet a beneficiary’s assessed need by one or both or
the following:
- Modifying or improving a beneficiary’s home
- Providing adaptive equipment

Note: Tangible equipment or hardware, such as technology assistance devices, adaptive
equipment, or environmental modifications, can be substituted for Personal Services when it is
identified as a cost-effective alternative on the beneficiary’s POC.

Purchase or rental of new or used tangible equipment or hardware under the definition of this service is
limited to those items not covered through regular Medicaid and which cannot be procured from other
formal or informal resources (such as vocational rehabilitation or educational system). This service will
be used only as the funding source of last resort. Tangible equipment or hardware requires PA from the
MFP PD program manager or other designated SRS staff.

Assistive services can include:
- Ramps
- Lifts
- Modifications to bathrooms and kitchens specifically related to accessibility
- Specialized safety adaptations
- Assistive technology that improves mobility or communication

Environmental modifications can only be purchased in rented apartments or homes when the landlord
agrees in writing to maintain the modifications for a period of not less than three years and will give first
rent priority to tenants with physical disabilities.

Specific Limitations
A beneficiary on the MFP PD waiver prior to his or her 65th birthday will have the option to choose to
remain on the PD waiver at the age of 65 years or to transfer to the MFP FE waiver. At any time after the
beneficiary’s 65th birthday, he or she can choose to transfer to the MFP FE waiver. A beneficiary can only
transfer once.

Specific Documentation Requirements
The provider must maintain an invoice or receipt that contains:
- Name of business or contractor
- Beneficiary’s first and last name and signature
- Identification of the technology or service being provided
- Date of service (MM/DD/CCYY)
- Amount of purchase
- Statement of inspection by provider to ensure product was purchased/installed as authorized
MFP PD ASSISTIVE SERVICES
Specific Enrollment
Providers of this service are contractors, agencies licensed by the county or city in which they work who perform all work according to existing building codes. All Assistive Services will be arranged by the PD targeted case manager and generally paid through a payroll agency with beneficiary-written authorization of the purchase. Beneficiaries will have complete access to choose any qualified provider (agency or individual). Individually qualified providers will not be given separate provider agreements but may choose to contract with any qualified provider agency or TCM PD agency.

Specific Reimbursement
Reimbursement for this service is limited to the beneficiary’s assessed level of services and based on the annualized care plan.

Enter diagnosis code 780.99 in Field 21 on the CMS-1500 claim form.
Enter procedure code S5165 in Field 24D of the CMS-1500 claim form.
One unit equals one purchase.
Purchase is limited to a maximum lifetime expenditure of $7,500 per beneficiary across waivers.
MFP PD PERSONAL SERVICES  
**AGENCY-DIRECTED AND SELF-DIRECTED**

Personal Services means one or more persons assisting another person who has a disability with tasks that the person with the disability 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 can be reimbursed when providing this service. Only under exception approval by the MFP PD program manager can parents of minor children or spouses be paid (K.A.R. 30-5-307).

No more than one Personal Services worker can be paid for services at any given time of the day nor is a Personal Services worker to work for two beneficiaries at the same time and date. Exceptions must be justified and documented by the targeted case manager, such as two-person lift for safety issues. Approval for these services will be given by the MFP PD program manager or designee. Medicaid nonwaivered home health services for MFP PD beneficiaries require PA.
Specific Limitations
A beneficiary on the MFP PD waiver prior to his or her 65th birthday will have the option to choose to remain on the PD waiver at the age of 65 years or to transfer to the MFP FE waiver. At any time after the beneficiary’s 65th birthday, the beneficiary can choose to transfer to the MFP FE waiver. A beneficiary can only transfer once.

Specific 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 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 services persons will, upon request, make such information available to federal and state agencies, law enforcement, the attorney general’s office, and legislative postaudit. 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.

Specific Documentation Requirements

In-Home Care
Documentation at a minimum must include the following:

- Identification of service being provided
- Beneficiary’s first and last name and signature (see Signature Limitations section)
- 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
MFP PD PERSONAL SERVICES AGENCY-DIRECTED AND SELF-DIRECTED
Specific Documentation Requirements (continued)

Assisted Living Facilities

Documentation at a minimum must include the following:
- Identification of service being provided
- Beneficiary’s name and signature (see Signature Limitations section)
- 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 provided but not authorized on the Attendant Care Worksheet and POC will be subject to recoupment.

Specific Enrollment
- All Personal Services will be arranged by and generally paid through the PD TCM agency or a payroll 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.
- Individual qualified providers will not be given separate provider agreements but can choose to contract with any qualified provider agency or PD TCM agency.

Specific 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.

Personal Services Agency-Directed
Enter diagnosis code 780.99 in Field 21 on the CMS-1500 claim form. For PD, enter procedure code S5126U9 in Field 24D of the CMS-1500 claim form. For TBI, enter procedure code S5126U9 in Field 24D of the CMS-1500 claim form.

Personal Services Self-Directed
Enter diagnosis code 780.99 in Field 21 on the CMS-1500 claim form. For PD, enter procedure code S5126U6 in Field 24D of the CMS-1500 claim form. For TBI, enter procedure code S5126UB in Field 24D of the CMS-1500 claim form.

One unit equals one hour.

A Medicaid beneficiary is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a beneficiary cannot exceed either the daily approved number of hours or weekly approved number of hours.
MFP TBI ASSISTIVE SERVICES
Assistive Services are those services which meet a beneficiary’s assessed need by modifying or improving a beneficiary’s home and through provision of adaptive equipment. Cost-effectiveness should be considered along with other factors, including quality of life, and level of independence when including Assistive Services in a POC.

Purchase or rent of new or used tangible equipment or hardware under the definition of this service is limited to those items not covered through regular Medicaid and which cannot be procured from other formal or informal resources (such as vocational rehabilitation or educational system). This service will be used only as the funding source of last resort. Tangible equipment or hardware requires PA from the TBI program manager or other designated SRS staff.

Assistive Services can include:
- Ramps
- Lifts
- Modifications to bathrooms and kitchens specifically related to accessibility
- Specialized safety adaptations
- Assistive technology that improves mobility or communication
- Shower chairs
- Commodes/walkers

Environmental modifications can only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years and will give first-rent priority to tenants with physical disabilities.

Specific Limitations
A beneficiary must be at least 16 years of age but less than 65 years of age to receive MFP TBI waiver services. However, if a beneficiary is receiving waiver services at age 65 and is still showing progress in their rehabilitation, special consideration may be given by the TBI program manager for him or her to remain on the waiver past the age of 65 until a time when he or she no longer significantly benefit from transitional living skills and rehabilitation therapies. If the beneficiary will be age 16 by the time services are due to begin, the assessment may be completed prior to age 16. If a beneficiary is 64 years of age at the time of the assessment, they must begin services before the age of 65 to be eligible.

Specific Provider Requirements
Providers of this service are contractors arranged through the targeted case management agencies (per K.S.A. 65-5101) or durable medical equipment (DME) providers meeting standards set forth in KAR 30-5-108. Contractors must be licensed according to the local and county codes where they work. Providers of DME must be enrolled vendors with the Medicaid agency, meeting standards set in KAR 30-5-108.
MFP TBI ASSISTIVE SERVICES

Specific Documentation Requirements

Documentation at a minimum must include the following:

- Provider must maintain a copy of the receipt identifying that the service was provided. At a minimum, the receipt must include:
  - Name of business or contractor
  - Identify technology/service being provided
  - Date of service (MM/DD/YYYY)
  - Amount of purchase
  - Beneficiary’s first and last name and signature
- Provider must provide a statement of inspection ensuring the product was purchased/installed as authorized.

Specific Reimbursement

- Reimbursement for this service is limited to the beneficiary’s assessed level of service need and based on the POC.
- All Assistive Services will be arranged by the targeted case manager with the beneficiary’s written authorization of the purchase.
- Beneficiaries will have complete access to choose any qualified provider. If the qualified provider does not wish to contract with the targeted case management agency, the State shall provide a separate provider agreement for that provider.
- This service must be reimbursed within the approved reimbursement range established by the State.
- A Medicaid beneficiary is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a beneficiary cannot exceed either the daily approved number of hours or weekly approved number of hours.
- Enter procedure code S5165 in Field 24D of the CMS-1500 claim form.
- One unit equals one purchase.
- Purchase is limited to a maximum lifetime expenditure of $7,500 per beneficiary. If a beneficiary is being served by the TBI waiver and Assistive Services greater than $7,500 are needed, a request may be made to the Administrative Review Committee and a determination as to override the limit will be made.

Plan of Care

Assistive Services must be approved by the TBI program manager or other designated SRS staff. The request should be submitted in writing to:  
TBI Program Manager SRS/HCP/CSS  
DSOB 10th Floor East  
915 SW Harrison  
Topeka, KS  66612

The targeted case manager should include in the letter the service being requested, reimbursement, and reason for the request. Supporting documentation such as a catalog price or estimate from a DME provider should also be provided. A response will then be sent to the targeted case manager of approval or denial. At that time, the targeted case manager will enter the service on the electronic POC.
MFP TBI PERSONAL SERVICES

Personal Services mean one or more persons assisting another person who has a traumatically acquired external brain injury resulting in residual deficits and disability with tasks that the beneficiary would typically do for themselves in the absence of the injury. Such services may include assisting the beneficiary in accomplishing any ADL or IADL associated with the 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).

Specific Limitations

MFP TBI services are available to beneficiaries who are Medicaid eligible. The beneficiary must meet the following criteria:

- Be a Kansas resident upon receiving services and for the duration of services
- Have been diagnosed with an external, traumatically acquired nondegenerative, structural brain injury resulting in residual deficits and disability

Note: Trauma is defined as a physical injury caused by external force or violence.

Examples of situations where the brain injury may have occurred include:

- Blow to the head
- Motor vehicular accident
- Fall to the ground
- Physical abuse
- Coup/Contre-Coup injuries
MFP TBI PERSONAL SERVICES
Specific Limitations (continued)

- Must be at least 16 but less than 65 years of age
  Note: However, if a person is receiving waiver services at 65 years of age and is still showing progress in their rehabilitation, special consideration may be given by the TBI program manager for him or her to remain on the waiver until no longer significantly benefiting from transitional living skills and rehabilitation therapies. If the beneficiary will be 16 years of age by the time services are due to begin, the assessment may be completed prior to turning 16. If a beneficiary is 64 years of age at the time of the assessment, he or she must begin services before 65 years of age to be eligible.
- Show the capacity to make progress in rehabilitation and the development of skills that promote independent living

Medicaid nonwaivered home health aide services for MFP TBI beneficiaries require PA.

No more than one personal service worker can be paid for services at any given time of the day nor is a personal services worker to work with more than one beneficiary at the same time and date. Exceptions must be justified and documented by the targeted case manager, such as two-man lift for safety issues. The TBI program manager must give approval for these services.

Specific Provider Requirements
All Personal Services will be arranged and authorized by the targeted case manager with the beneficiary’s written authorization of the purchase. Beneficiaries will have complete access to choose any qualified provider who can meet their personal service needs. Only agencies can enroll to provide this service. Individual providers must be 18 years of age and older. Individuals who qualify to provide Personal Services cannot enroll as individual but may contract with any organization that is a qualified provider of Personal Services and the TBI waiver. Family members can be reimbursed when providing these services. However, under no circumstances will parents of minor children or spouses be paid unless special exception criteria have been met per K.A.R. 30-5-307 and approved by the TBI program manager or other designated SRS staff.

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
MFP TBI PERSONAL SERVICES
Specific Provider Requirements (continued)

- 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.

Specific Documentation Requirements
Documentation must be legible and at a minimum must include the following:

- Identification of service being provided
- Beneficiary’s first and last name and signature, each visit (see Signature Limitations section)
- Attendant’s name and signature, each visit
- 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

Specific Reimbursement
Enter procedure code S5126 UC in Field 24D of the CMS-1500 claim form.
One unit equals one month.
Expected Service Outcomes For Individuals or Agencies Providing MFP Services
Updated 04/10

1. Services are provided according to the POC and Attendant Care Worksheet and in a quality manner and as authorized on the Notice of Action.

2. Services are coordinated and provided in a cost-effective and quality manner.

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

4. Communicate beneficiary concerns, needs, and changes in health status to the targeted 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 POC and Attendant Care Worksheet must be reported immediately, but not to exceed 48 hours, to the targeted case manager.