



Kansas Medical  
Assistance  
Program



KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

**Professional**

**PART II  
PROFESSIONAL SERVICES PROVIDER MANUAL**

**INTRODUCTION**

<b>Section</b>		<b>Page</b>
	<b>BILLING INSTRUCTIONS</b>	
7000	CMS-1500 Billing Instructions .....	7-1
	Submission of Claim Form .....	7-7
7010	Specific Billing Information .....	7-8
	<b>BENEFITS AND LIMITATIONS</b>	
8100	Copayment .....	8-1
8200	Reserved for Future Use .....	8-1
8300	Benefit Plans .....	8-2
8400	Medicaid Program Overview .....	8-3
	Abortion .....	8-3
	ACH Services .....	8-4
	Ambulance .....	8-5
	Apnea Monitors .....	8-6
	Audiology .....	8-7
	Cardiac Rehabilitation .....	8-10
	Children and Family Services Contractors .....	8-11
	CMHC .....	8-11
	Consultations .....	8-11
	CPAP .....	8-11
	Dental .....	8-11
	Developmental Testing .....	8-12
	Dietitian Services .....	8-12
	Documentation .....	8-12
	DME .....	8-12
	EKGs .....	8-12
	Emergency Services for Aliens .....	8-13
	Family Planning .....	8-13
	Hospice .....	8-13
	Hospital .....	8-13
	Hyperbaric Oxygen Therapy .....	8-21
	Immunizations .....	8-21
	Injections .....	8-22
	Intrathecal Baclofen Pump .....	8-22
	Laboratory .....	8-22
	LEA Services .....	8-23
	Maternity Center Services .....	8-23
	Mid-Level Practitioners .....	8-24
	Nursing Facility .....	8-24
	OB/Gynecological .....	8-24
	OB Sonograms .....	8-25
	Office Visits .....	8-25
	Oxygen Therapy .....	8-26
	Pain Management .....	8-31

<b>Section</b>		<b>Page</b>
8400 (cont.)	Patient Demand Cardiac Monitoring ... .. .	8-34
	Pharmacy .....	8-34
	Prosthetic and Orthotic Devices .....	8-36
	Psychiatric .....	8-37
	Radiology .....	8-38
	Renal Dialysis/Kidney Transplants .....	8-42
	Sterilizations .....	8-43
	Surgery .....	8-46
	Therapy (Rehabilitative) .....	8-48
	Transplants .....	8-49
	Tuberculosis ..	8-50
	Vagal Nerve Stimulators .....	8-50
	Vision ..	8-51
	Vacuum Assisted Wound Closure Therapy .....	8-51
	<b>LOCAL HEALTH DEPARTMENT</b>	
8420	Family Planning .....	8-52
	Skilled Nursing Services .....	8-52
	Prenatal Health Promotion and Risk Reduction (PHP/RR) ....	8-52
	Prenatal Health Promotion/Risk Reduction	
	High Risk Nutrition Services (PHP/RRHRN) ..	8-54
	Prenatal Health Promotion/Risk Reduction	
	Enhanced Social Work Services (PHP/RRESW) .....	8-55
	Postpartum/Newborn Home Visit (PP/NBHV) .....	8-56
	Dental Services .....	8-57
	<b>KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT</b>	
8430	<b>STATE LABORATORY</b> .....	8-58
	<b>Appendix</b>	
Appendix I	Codes .....	AI-1
<b>FORMS</b>	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.	

*CPT codes, descriptors, and other data only are copyright 2010 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>.*

# PART II

## PROFESSIONAL SERVICES

### Updated 10/09

This is the provider specific section of the manual. Part II was designed to provide information and instructions specific to professional services providers. It is divided into ~~three~~ ~~four~~ subsections: Billing Instructions, Benefits and Limitations ~~and~~ Appendices, ~~and~~ Forms.

**Billing Instructions** contains instructions on completion and submission of the CMS-1500 claim for paper billers.

**Benefits and Limitations** defines specific aspects of the scope of services covered within the KHPA Medical Plans.

The **Appendix** contains information concerning ~~procedure codes.~~ ~~These appendices were developed to make finding and using procedure codes easier for the biller.~~

**Forms** are on the public (<https://www.kmap-state-ks.us/Public/forms.asp>) and the secure (<https://www.kmap-state-ks.us/provider/security/logon.asp>) websites. ~~(contains forms specific to providers of professional services.~~ These forms may be duplicated for your use, except the sample claim forms. ~~Nonspecific forms (e.g., Prior Authorization, Medical Necessity) are located in Part I of this provider manual.~~

### HIPAA Compliance

As a ~~KMAP~~ participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

# BILLING INSTRUCTIONS

7000. Updated 10/09

## THE CMS-1500 CLAIM FORM

Providers of professional services must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under KHPA Medical Plans. 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 both the public and secure websites (see the Table of Contents and Introduction pages for hyperlinks) ~~in the forms section at the end of this manual~~. Instructions for completing this form are included on the following pages.

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. Refer to Section 1100 of the *General Introduction Provider Manual*.

**Complete the following CMS-1500 claim form fields when applicable:**

**Fields not identified below should be left blank.**

Field 1      **Program Identification:**  
Check appropriate box(es).

Field 1A      **Insured's ID Number:**  
Enter the 11-digit beneficiary identification (ID) number from patient's KMAP ID card. If newborn services, use mother's beneficiary ID number if newborn's number is unknown.

Field 2      **Patient's Name:**  
Enter patient's last name, first name, and middle initial exactly as it appears on the medical ID card. If patient is a newborn, enter "newborn", "baby boy", or "baby girl", in the first name field and enter the last name.

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BILLING INFORMATION

**7000. Updated 09/07**

- Field 3      **Patient's Date of Birth:**  
Enter patient's date of birth as month, day and year - MM/DD/YYYY  
(For example, October 1, 1957, would be listed as 10/01/1957). If  
newborn services, enter baby's date of birth (not mother's).
- Patient's Sex:**  
Check the appropriate box.
- Field 5      **Patient's Address:**  
Enter patient's street address including city, state and zip code.
- Field 9      **Other Insured's Name:**  
If patient has secondary or supplemental insurance complete fields 9  
and 9A-D. (Enter the primary insurance information in field 11.)
- Field 10     **Is Patient's Condition Related To:**  
Check appropriate box when billing for **accident related services  
only**. If box is checked:
- Enter all available information in field 11.
  - Check "other" box if related to "child abuse" or a "self inflicted"  
injury and note "child abuse" or "self inflicted" in field 10D.
- Field 11     **Insured's Policy Group or FECA Number:**  
This field should be completed if the patient has insurance primary to  
Medicaid. If yes, complete fields 11 and 11a-d.
- Field 14     **Date of .....**  
Complete field when billing for accident related services only. Enter  
date of accident in MM/DD/YY format. Otherwise, leave blank.
- Field 17A    **I.D. Number of Referring Physician:**  
Enter either **qualifier '1D'** and a 10-digit KMAP provider ID (or all  
nines if the referring physician is not a KMAP provider), or the enter  
**qualifier 'ZZ'** and a taxonomy code.
- Field 17B    **Provider's NPI:**  
Enter the provider's NPI.

**7000. Updated 05/07**

**Field 17a I.D. Number of Referring Physician:**

Enter the 10 digit **provider number** of the referring/ordering physician. ~~Enter all nines if the referring physician is not a Medicaid provider.~~

**Field 18 Hospitalization Dates Related to Current Services:**

Enter dates of admission and discharge.

**Field 20 Outside Lab?**

Check appropriate box:

If "no," bill for procedures performed.

If "yes," provider who actually performed service must bill.

**Field 21 Diagnosis or Nature of Illness or Injury:**

Enter the appropriate ICD-9-CM code. If more than one diagnosis applies, list the primary on line 1, secondary on line 2, etc.

**Field 22A Original Ref. No.**

If this is a resubmission of a claim, enter the previous internal control number (ICN).

**Field 23 Prior Authorization Number:**

Enter the assigned prior authorization (PA) number from the approval letter, if applicable.

**Field 24A Date(s) of Service:**

Enter date of service in MM/DD/YY format. If multiple services were performed on **consecutive** dates, give beginning date in "from" and give the last date of service in the "to" field and complete the units field (24G) accordingly.

**7000. Updated 05/07**

**Field 24B Place of Service:**

Enter appropriate "place of service code" for each service. Not all of the place of service codes may be appropriate for the service provided. Indicate the place of service code that most accurately reflects where the service was provided.

- |                                 |   |
|---------------------------------|---|
| 11 – Office                     | 41 – Ambulance - Land                           |
| 12 – Home                       | 42 – Ambulance-Air or Water                     |
| 21 – Inpatient Hospital         | 50 – Federally Qualified Health Center (FQHC)   |
| 22 – Outpatient Hospital        | 53 – CMHC                                       |
| 23 – Emergency Room - Hospital  | 54 – ICF/MR                                     |
| 24 – Ambulatory Surgical Center | 65 – End Stage Renal Disease Treatment Facility |
| 31 – Skilled Nursing Facility   | 71 – Local Health Department                    |
| 32 – Nursing Facility           | 72 – Rural Health Clinic (RHC)                  |
| 33 – Custodial Care Facility    | 81 – Independent Laboratory                     |
| 34 – Hospice                    | 99 – Other Locations                            |

**Field 24D Procedures, Services, or Supplies:**

Enter HCPCS 5-digit base procedure code (add modifier(s) if appropriate). Explain unusual circumstances.

**Field 24E Diagnosis Code:**

Enter the appropriate line number from field 21.

**Field 24F Charges:**

Enter your **usual** and **customary** charge for each service.

**Field 24G Days or Units:**

Enter number of visits, days or units of service rendered, as applicable to each detail line. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) should bill only one encounter per claim detail.



**7000. Updated 09/07**

Field 24H **EPSDT Family Plan:**

**COB: (EPSDT/KBH referral value)**

Enter the 2-digit value when an EPSDT (KAN Be Healthy) screen results in a referral. The value choices include:

AV – the beneficiary refused the referral

S2 – the beneficiary is currently under treatment

ST – new services requested

**EPSDT / Family Planning:**

Enter “E” when completing an EPSDT (KAN Be Healthy) screen.

Enter “F” when completing a Family Planning visit.

Enter “B” when both, an EPSDT (KBH) and Family Planning visit, are completed.

Field 24I **ID Qualifier:**

Enter qualifier ‘ZZ’ if billing with a taxonomy code in the top half of field 24J. Enter qualifier ‘1D’ if billing with a KMAP provider ID in the top half of field 24J.

Field 24J **Rendering Provider ID #:**

Top half should be a 10-digit KMAP provider ID or a taxonomy code. Bottom half should be an NPI.

Field 26 **Your Patient's Account Number:**

**OPTIONAL:** Any alpha/numeric character entered in this field will be referenced on the Remittance Advice. No unique characters should be indicated, e.g., \*, @, -, #, etc.

Field 27 **Accept Assignment:**

Leave blank. All providers of Kansas Medical Assistance Program services must accept assignment in order to receive payment on a Medicare related claim.

7000. Updated 05/07

Field 28

**Total Charge:**

Enter total of all itemized charges on this page of the claim. If filing more than one claim page for the same beneficiary, total each claim page separately. **(Do not include co-payment amount, refer to Section 8100.)**

When more than one claim page is utilized for the same beneficiary, for the same date of service, follow the instructions below:

- 1) Ensure the claims are sent to Medicaid together by not tearing the claims apart or by paper clipping the claims together. Do not staple together the claims.
- 2) Do not total the charges in Field 28.
- 3) Enter "Continued. Page \_\_ of \_\_" in Field 28. For example, when 10 procedures were provided for the same beneficiary on the same date of service enter, "Continued. Page 1 of 2."
- 4) Enter the total charge in Field 28 of the last claim form. According to the example above, the total charge would be in Field 28 on page 2.

Field 29

**Amount Paid:**

Enter any amount paid by insurance or other third party sources known at the time the claim is submitted. If the amount shown in this field is the result of other insurance, documentation of the payment must be attached. (Field 11 must identify the other insurance source.) Refer to Sections 3200 and 3300 for more specific information.

**Do not enter co-payment or spenddown payment amounts. They are deducted automatically.**

**NOTE:** Retain proof of other insurance payment in the beneficiary's file.

Field 30

**Balance Due:**

Subtract block 29 from 28 and enter the balance here.

Field 31

**Signature of Physician or Supplier:**

Read statement on back of claim form, sign and date.

- Phrase "signature on file" is acceptable.
- Provider's name typed/stamped is acceptable.

Field 32A

**Provider's NPI:**

Enter the provider's NPI.

Field 32B

**KMAP Provider ID or Taxonomy Code:**

Enter either a 10-digit KMAP provider ID or a taxonomy code.

Field 32

**Name and Address of Facility Where Services Rendered:**

Enter name and address of facility (if other than patient's home or provider's facility).

**7000. Updated 09/07**

- Field 33      **Billing Provider Info & Ph #:**  
This information regarding the group number corresponds with the provider information provided in fields 33A and 33B
- Field 33A    **Provider's NPI:**  
Enter the provider's NPI.
- Field 33B    **KMAP Provider ID or Taxonomy Code:**  
Enter qualifier '1D' and the 10-digit KMAP provider ID or qualifier 'ZZ' and a taxonomy code.

**Submission of Claims:**

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program  
Office of the Fiscal Agent  
P.O. Box 3571  
Topeka, KS 66601-3571

## SPECIFIC BILLING INFORMATION

### 7010. Updated 10/09

#### Allergy

When billing for an allergy evaluation, follow the instructions in the *CPT*® codebook and utilize Evaluation and Management (E&M) office visit codes.

The number of units in field 24G for allergen immunotherapy should equal either the number of injections or the number of antigens, dependent upon the code billed.

#### Anesthesia

Medicaid claims for anesthesia shall be billed using the American Society of Anesthesiologists (ASA) codes. Medical direction or supervision of anesthesia services by an anesthesiologist cannot be billed in addition to certified registered nurse anesthetist (CRNA) anesthesia services. Only direct patient time should be billed, not wait time.

In field 24G, indicate the number of **minutes** anesthesia was administered. Give only whole numbers. Round all decimals upward to the nearest whole number. Example: 13.4 minutes of anesthesia administered should be indicated as 14 in field 24G.

#### Chemotherapy

Chemotherapy injection codes (96400-96450) must be used for chemotherapy **administration**.

Chemotherapy **drugs** should be billed with the appropriate **injection procedure** code. (Refer to Appendix I.) For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp> or from the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations.

#### Children Immunization Administration

Please see **Immunization Administration** in this section.

#### 'E' Diagnosis Codes

External causes of injury and poisoning diagnosis ('E') codes are accepted as a secondary diagnosis when billed in conjunction with a covered primary diagnosis code.

#### End Stage Renal Disease

As of August 1, 2008, providers can enroll to perform end-stage renal disease (ESRD) services with KHPA as a provider type and specialty 30/300 (Renal Dialysis Center).

#### Emergency Room Services

The **primary** diagnosis code must reflect the **emergent condition** (presenting symptoms). Refer to the *CPT*® codebook for levels of care definitions when selecting the appropriate procedure to bill.

## 7010. Updated 04/10

### Exempt License Physicians

License-exempt physicians (retired), performing services in a clinic setting, can enroll as a Medicaid provider. The clinic is reimbursed for expenses incurred for providing such services. The billing provider should be the clinic, and the performing provider should be the exempt licensed physician. Claims will be reimbursed at 75 percent of the maximum allowable.

### Immunization Administration

Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of *CPT*® codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed.

PACS software requires a charge on each line item being submitted. Providers that bill electronically through the PACS system will need to indicate a charge of \$.01 on the line for the vaccine/toxoid code. The MMIS system will deny the service even though a charge was submitted.

Codes 90470 and G9141 are covered for the administration of the H1N1 vaccine. These codes are covered for all benefit plans, except for beneficiaries who only have ADAPD coverage, with a reimbursement rate of \$14.15. Claims for the administration of the H1N1 vaccine should be billed with diagnosis code V04.81 (H1N1). Since the H1N1 vaccine is available at no cost to providers, payment is not being issued for 90663 or G9142. If providers are interested in administering the H1N1 vaccine, they can contact the Kansas Department of Health and Environment (KDHE) to receive the vaccine.

### Injections

In Field 24D, enter the code, strength and dosage. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website or under Pricing and Limitations on the secure website (see Appendix I for hyperlinks). A predetermination request may be submitted if it is felt a specific injection should be covered. Refer to Section 4200 of the *General Special Requirements Provider Manual*.

Code 96372 is to be billed when the patient furnishes his or her own medication and reimbursement is only for the administration of the injection. It is not to be billed in conjunction with an injection code.

### Laboratory Panels/Profiles

Only the provider performing the laboratory analysis can bill.

When ordered laboratory tests make up a panel or profile, the all-inclusive code should be used to bill. Do not bill each component separately.

### Locum Tenens Physicians

- Locum tenens physicians must not be in place for more than one year.

**7010. Updated 04/10**

**Locum Tenens Physicians continued**

- It is the provider's responsibility to insure a locum tenens physician covering for a KMAP provider is not excluded from participation in governmental programs including Medicaid.
- Upon review of claims, payments will be recouped if it is determined that KMAP paid for a service that was provided by a locum tenens physician who was excluded from participation in governmental programs including Medicaid on the date of service.

**Mid-Level Practitioners**

Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) must be enrolled as Medicaid providers to bill for services. Indicate the clinic's number as the billing provider and the PA's or ARNP's number as the performing provider on the CMS-1500 claim form. ARNPs and PAs are reimbursed at 75 percent of the Medicaid allowed amount for services provided.

**Missed Appointments**

Providers should not bill beneficiaries for missed appointments. Missed appointments are not a distinct reimbursable service but are a part of the providers' overall cost of doing business.

**Newborn Services (When the birth mother is NOT assigned to a KMAP MCO)**

Only procedure codes which specifically state "newborn" in the code description according to the CPT® codebook are considered newborn services. These services can be paid under the mother's beneficiary ID number for the first 45 days after the baby's date of birth. These services must be billed with a newborn diagnosis code in order to receive payment.

When billing newborn services for a newborn who does not have a beneficiary ID number, use "Newborn", "Baby Girl", or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's beneficiary ID number. The claim will suspend in the claims processing system for up to 45 days pending the fiscal agent's receipt of the newborn's beneficiary ID number from the eligibility system. If the newborn's ID number is received within 45 days, the claim will be processed using that number. If the newborn's ID number is not received within 45 days, the claim will complete processing with the mother's ID number.

This process is to be used when billing the following CPT® codes:

31520	36660	54160	99460	99463	99468	99472	99478
36450	54000	94652	99461	99464	99469	99475	99479
36510	54150	99297	99462	99465	99471	99476	99480

**Newborn Services (When the birth mother is assigned to a KMAP MCO)**

Notify the birth mother's assigned MCO of the birth, at which time the MCO will provide billing instructions. The mother's MCO will notify the eligibility system and the fiscal agent of the birth.

**7010. Updated 04/10**

**Nonhospital-Based Physician Services**

Nonhospital-based physicians are:

- Physicians who are called to the emergency room (ER) when one of their patients presents for services.
- Emergency physician groups who staff ERs but do their own billing.

When nonhospital-based physicians **assigned** to the emergency department render services in the ER, the following procedure codes should be utilized for billing: 99281, 99284, 99282 and 99285.

When nonhospital-based physicians **not assigned** to the emergency department render services in the ER, the following procedure codes should be utilized for billing:

<b><u>EMERGENT</u></b>	<b><u>NONEMERGENT</u></b>
99281 thru 99285	99201 thru 99215 or 99056

**Obstetrical and Gynecological**

If you have not provided total obstetrical care and delivery but did provide predelivery or postdelivery visits, refer to Section 8400 for appropriate codes.

Bill prenatal laboratory services using the corresponding code for each test performed or use the OB panel code. **(Routine urinalysis is content of service of prenatal care.)**

When billing for twins delivered by the same method, both vaginally or both cesarean, use the appropriate code and indicate 1.5 in the units field. If twins were delivered by different methods, one vaginal and one cesarean, use the appropriate code for each and indicate 1 in each of the units field.

**Professional/Technical Component Billing**

**Professional:**

In field 24D, enter the HCPCS base code for services rendered, including **modifier 26**. (Example: **7207026**)

**Technical:**

In field 24D, enter the HCPCS base code of the service performed, including **modifier TC**. (Example: **72070TC**)

**Professional and Technical:**

In field 24D, enter the HCPCS base code of the service performed. (Example: **72070**)

**The same procedures performed on the same day:**

- Must be billed on the same claim
- Must clarify in field 24D the reason for billing more than one procedure (such as two X-rays at two different times; left arm, right arm)

**7010. Updated 04/10**

When same procedures are not billed on the same claim, the additional claim(s) will be denied as a duplicate.

To seek reimbursement for additional services when this occurs, submit an underpayment adjustment using the ICN from the remittance advice (RA) of the paid claim, **and** state on the adjustment request that more than one procedure was performed on the same day. Refer to Section 5600 of the *General Billing Provider Manual* for details.

**Related Services Provided During a Psychiatric Hospitalization**

The primary care physician's referral is not required when billing for related physician and ancillary services provided during a psychiatric hospitalization approved through the preadmission assessment process. Indicate the admit and discharge date of the hospitalization in Field 18.

**Surgery**

**Always** break down charges for each procedure.

When billing multiple surgical procedures on the same date of service, bill the comprehensive procedure as the primary procedure as detail 1 on the claim. Bill all surgical procedures on the same claim.

When billing for multiple surgical procedures on the same day, bill your usual and customary charge for all procedures. Medicaid will reduce subsequent procedures for you.

**Assistant Surgeon**

In Field 24D, enter the base code for the surgery performed, including modifiers 80, 81, 82 or AS, as appropriate. (Example: **3369280**)

**Bilateral Procedures**

Procedures performed bilaterally during a single operative session must be identified with the appropriate code. When a procedure is identified in the *CPT*<sup>®</sup> codebook as one that should have modifier 50 added to the base code when performed bilaterally, bill the procedure as a single line item with modifier 50. Procedures billed with modifier 50 must be billed only once on the claim as one unit. For example, a bilateral tympanostomy must be billed indicating code 6943650 as one unit.

When a code states “unilateral or bilateral” in the description, do not add modifier 50. In this instance, the base code is billed only once on the claim and the number of units is one. For example, code 58900 equals one unit.

**Supplies and Accessories**

For splints and accessories supplied by the provider over and above those usually included with the office visit or other services rendered, use the code that best fits the item. If a specific code cannot be found, use code 99070 and list the drugs, trays, supplies or materials provided.



## 7010. Updated 01/10

### **Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient**

Effective with claims processed on and after February 2, 2010, and retroactive to dates of service on and after January 15, 2009, the KHPA Medical Plans will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicaid will also not cover hospitalizations and other services related to these noncovered procedures. None of the erroneous surgeries or services are billable to the beneficiary.

All services provided in the operating room when an error occurs are considered related and therefore are not covered. All providers in the operating room when the error occurs who could bill individually for their services must submit claims for these services but are not eligible for reimbursement for these services. All of these providers must submit separate claims for these services using the appropriate methods.

#### **Inpatient Claims**

Hospitals are required to bill two claims when the erroneous surgery(s) is reported.

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11X (with the exception of 110)
- One claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)
  - The noncovered TOB 110 will be required to be submitted on the UB-04 (hard copy) claim form.
  - For claims on and after January 15, 2009, through September 30, 2009, providers are required to report in form locator (FL) 80 Remarks, one of the applicable two-digit surgical error codes as follows:
    - MX: For a wrong surgery on patient
    - MY: For surgery on the wrong body part
    - MZ: For surgery on the wrong patient

Providers are required to report as an “other diagnosis” one of the applicable External Cause of Injury Codes for wrong surgery performed:

- E876.5: Performance of wrong operation (procedure) on correct patient
- E876.6: Performance of operation (procedure) on patient not scheduled for surgery
- E876.7: Performance of correct operation (procedure) on wrong side/body part

**Note:** These E codes are **not** to be submitted in the E code field on the UB-04.

#### **Outpatient, Ambulatory Surgical Centers, Other Appropriate Bill Types and Practitioner Claims**

For dates of services on and after July 1, 2009, the providers are required to append one of the following applicable modifiers to all lines related to the erroneous surgery(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

## **BENEFITS & LIMITATIONS**

### **8100. COPAYMENT Updated 11/03**

**Ambulatory/OP surgical center** services require a copayment of \$3.00 per day.

**ARNP** and **local health department** services are exempt from copayment requirements.

**Dietitian** services require a copayment of \$2.00 per date of service for KAN Be Healthy participants 18 years of age and older.

**FQHC** services require a copayment of \$3.00 per encounter.

**Physician** services require a copayment of \$2.00 per office visit.

**Psychotherapy** services require a copayment of \$2.00 per date of service when provided in the office.

**RHC** services require a copayment of \$2.00 per encounter.

Bill all services occurring on the same date on the same claim form.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.

**Do not reduce charges or balance due by the copayment amount. This reduction is automatically made during claim processing.**

### **8200.**

Reserved for future use

# BENEFITS & LIMITATIONS

## 8300. Benefit Plans Updated 12/08

KMAP beneficiaries are will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

For more information about benefit plans, refer to the *General Benefits Provider Manual*. For example, coverage for the MediKan benefit plan is the same as for Medicaid beneficiaries (refer to Section 8400) with the following exceptions:

- ~~Current Medicaid limitations for psychiatric admissions continue to apply.~~
- ~~Psychotherapy is limited to a maximum of 24 hours per calendar year.~~
- Inpatient general hospital services are covered for MediKan beneficiaries for the following conditions only:
  - Acute psychotic episodes
  - Alcohol and drug detoxification
  - Burns
  - ~~Mental health~~
  - Severe acute traumatic injuries
  - Tuberculosis

Physicians should be aware that hospital admissions coverage determination for MediKan beneficiaries are will be based reviewed and consideration of payment made based on the nature of the injury indicated by the diagnosis on the claim and by the medical documentation submitted.

**Note:** If medical documentation is not submitted, the claim will be denied.

# BENEFITS & LIMITATIONS

## 8400. MEDICAID PROGRAM OVERVIEW **Updated 10/09**

The following Benefits and Limitations provide an overview of covered Kansas Medical Assistance Program services that can be utilized in the beneficiary's total treatment. The following information is intended to be general in nature and not inclusive of every benefit and limitation.

If more information is desired, call Customer Service. (Refer to Section 1000 of the *General Introduction Provider Manual*.)

### **Abortion**

Abortions are covered only under the following conditions:

- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.
- Use modifier G7 when billing for abortion services if the pregnancy is the result of an act of rape or incest.

The physician must complete the Abortion Necessity Form to certify that the woman's physical health is in danger, or that this pregnancy is a result of rape or incest. The Abortion Necessity Form is located ~~in the Forms section at the end of this manual and under Publications/Forms/Abortion Necessity Form~~ on the public and secure websites (see the Table of Contents and Introduction pages for hyperlinks). The form may be photocopied for your use. All fields **must** be completed, including the patient's complete address. All pertinent information must be retained with the medical record.

**8400. Updated 11/03**

**Adult Care Home Services**

The Adult Care Home (ACH) Program provides room and board, plus all routine services and supplies required by patients. To place a Kansas Medicaid beneficiary in a long-term care facility, it must first be determined placement is appropriate. The CARE (Client Assessment Referral Evaluation) screening program is designed to identify the community based service needs of the individual and determine whether a Level II PASARR (Preadmission Screening and Annual Resident Review) is required. Providers should contact the local Area Agencies on Aging for non-Medicaid applicants. For Medicaid-eligible applicants contact the local SRS area office.

**Requirements for Supervision of ACH Patients**

Federal regulations set minimum standards with which the state must comply if it is to continue payment to the provider and the adult care home.

**I. Admission Evaluations**

**Nursing Facilities:** A medical evaluation must be forwarded to the facility which includes diagnoses, a summary of current medical findings, medical history, mental and physical functional capacity and prognosis.

**NF/MH:** Requirements are the same as for nursing facilities. In addition, appropriate professional personnel must make a psychiatric evaluation which shall be forwarded to the facility upon approval.

**ICF/MR:** Requirements are the same as for nursing facilities. In addition, appropriate professional personnel must make a psychiatric evaluation and summary of developmental findings which shall be forwarded to the facility upon approval.

Recertification, medication check and/or plan of care review is considered content of service of the ACH visit and is not covered if billed separately. No other ACH visits are covered on the same day as an ACH history and physical.

**II. Annual Medical Evaluation**

By State Health Department regulations, an annual medical evaluation must be completed on each adult care home resident to include a history and physical with updated diagnosis and prognosis. Tests or observations of the resident indicated by his/her medication regimen must be made when appropriate and properly documented.

## 8400. Updated 11/03

### ACH Visits

One routine visit per month is covered. If more than one ACH visit is required per resident, per month, medical necessity must be attached to the claim. (Refer to Section 4000 of the *General Special Requirements Provider Manual*.)

Recertification, medication check and/or plan of care review is considered content of service of the ACH visit and is not covered if billed separately.

One ACH history and physical is covered every 330 days per beneficiary, regardless of provider. No other ACH visits are covered on the same day as an ACH history and physical.

## Ambulance

### Emergency Transportation

The use of an ambulance must be medically necessary. (Refer to Section 4100 of the *General Special Requirements Provider Manual* for medical necessity documentation criteria.) The patient's condition must be such that the use of any other method of transportation is not possible without placing the patient's health in serious jeopardy, seriously impairing bodily functions, or results in serious dysfunction of any bodily organ or part. Some examples of "medical necessity" are:

- Transporting in an emergency situation (accident, injury, acute illness)
- Patient needs to be restrained
- Unconscious or in shock
- Requires oxygen or other emergency treatment
- Immobilizing fracture or possible fracture
- Acute stroke or myocardial infarction
- Hemorrhaging
- Bedridden
- Requires a stretcher or gurney

### Nonemergent Ambulance Transportation and Medical Necessity

All nonemergent transportation requires medical necessity. A medical necessity (MN) form must be attached to the claim at the time of submission. See the examples below:

- Routine transportation for nonambulatory patients
- Transportation from the patient's home to the hospital (or hospital to the patient's home)
- Transfers between hospitals

## 8400. Updated 11/03

### **Guidelines for Use of Air Ambulance Services**

**Time:** If time is a critical factor in the patient's recovery or survival, or duration of ground transport would be excessive and potentially detrimental, air transport may be indicated. In general, if the ground ambulance can arrive at the destination institution within 20 minutes, it is the preferred mode of transport.

**Expertise:** If the health care institution does not possess the expertise to provide the definitive care required to stabilize the patient (i.e., advanced life support) and the ground ambulance providers in the near vicinity cannot provide assistance in providing that care, air transport may be indicated.

**Coverage:** If ground ambulance utilization leaves the service area without adequate ground coverage and patient outcome will be compromised by arranging other ground transport, air transport may be indicated.

**Documentation:** The above guidelines serve as a guide to documentation which is necessary to determine proper reimbursement and must specify the indication and justification for air transport. If guidelines are not met, or are met but not documented, the billed transportation will be reimbursed at ground ambulance rates or denied altogether.

### **Apnea Monitors**

Determination of the medical necessity for a home apnea monitor is based on factors placing the infant at risk for sudden death as well as on the infant's age. The monitoring device must be ordered by a physician. Home monitoring is medically necessary in infants at risk for sudden death for up to six months of (corrected) age, and up to one year of (corrected) age in infants with bronchopulmonary dysplasia requiring home oxygen. Corrected age is defined as the age of the child had he or she been born at full term (i.e., a child born four weeks premature would not become one year of corrected age until one year and four weeks after the delivery date). The prescribing physician must indicate the length of time he or she feels the apnea monitor will be necessary.

An infant with the following factor(s) is considered to be at risk:

- One or more apparent life-threatening event(s) requiring adult intervention, such as mouth-to-mouth resuscitation or "shaken baby syndrome" may occur.
- Sibling of one or more sudden infant death syndrome victim(s).
- A newborn who continues to have apnea when he or she would otherwise be ready for care at home. Gestational age at discharge and frequency and dates of apneic episodes while hospitalized will assist in determining this condition.
- Bronchopulmonary dysplasia. Indicate whether or not oxygen is required following hospital discharge.
- Tracheostomy.
- Certain diseases/conditions associated with apnea or impaired ventilation, such as central hypoventilation.

#### 8400. Updated 10/09

A risk factor must be demonstrated on each beneficiary through the accurate completion of the Home Monitor Informational Form or similar medical necessity form providing the same information. Refer to the Forms ~~section~~ page on the public or secure website for an example of an acceptable Home Monitor Informational Form (see the Table of Contents and Introduction pages for hyperlinks.) The form(s) and valid prescription (dated on or prior to service dates) must be retained in the files of the provider supplying the monitoring device and are to be provided upon request.

If the beneficiary has used an apnea monitor longer than six months, the Home Monitor Informational Form and copy of a valid prescription are required to be attached to the claim when billing for the seventh month. Claims billed for apnea monitor rental for the seventh month and beyond are reviewed for medical necessity, **regardless of provider**. Documentation supporting continued need for the apnea monitor must accompany the claim. This documentation should include information from the past six months regarding any apneic episodes or conditions that put the child at risk and indicating continued need of the monitor.

#### **Audiology**

The following audiology services are covered under KMAP:

- Audiological testing, ear examinations, and evaluations
- Dispensing and repair of hearing aids
- Trial rental of hearing aids
- Batteries

Limitations on covered services are outlined below and on the following pages.

#### **Batteries**

Batteries are limited to six per month for monaural hearing aids and 12 per month for binaural hearing aids. **PA will not override these limitations**. Batteries for use with cochlear devices are limited to lithium ion (three per 30 days) and zinc air (six per 30 days). Batteries for cochlear devices are covered for KAN Be Healthy (KBH) eligible beneficiaries only. Only one type of battery is allowed every 30 days.

#### **Bone Anchored Hearing Aid**

~~Effective with dates of service on and after March 1, 2009, a~~ bone anchored hearing aid (BAHA) is covered by KMAP with the following specifications and limitations. A BAHA is limited to one every four years, with one replacement. PA is required for all BAHA services. All providers must obtain a PA prior to providing service.

A BAHA is covered with PA for a KBH beneficiary who meets all of the following criteria:

- **Each** of items one, two, three and four
- **Either** items five or six
- **At least one** of items seven, eight or nine
  1. The beneficiary must be five years of age or older.
  2. Standard hearing aids cannot be used due to a medical condition.
  3. The beneficiary has adequate manual dexterity or the assistance necessary to snap the device onto the abutment.



**8400. Updated 02/09**

**Bone Anchored Hearing Aid (continued)**

4. The beneficiary has the ability to maintain proper hygiene at the site of the fixture.
5. Tumors of the external canal and/or tympanic cavity are present.
6. Congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear are present.
7. There is unilateral conductive or mixed hearing loss.
8. There is bilateral conductive hearing loss.
9. There is unilateral sensorineural hearing loss (single-sided deafness).

**Definitions**

- **Unilateral conductive or mixed hearing loss:** Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Beneficiary must have:
  - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
  - Speech discrimination score greater than 60 percent in the indicated ear
- **Bilateral conductive hearing loss:** Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Beneficiary must meet all of the following:
  - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
  - Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies
  - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)
- **Unilateral sensorineural hearing loss (single-sided deafness):** Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skull. Therefore, the audiometric criteria are for the good ear. Beneficiary must meet all of the following:
  - Severe (70dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
  - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20dB (at 500, 1000, 2000, 3000 Hz)

A child younger than five years of age with unilateral congenital atresia of the ear canal or middle ear in the presence of a maximum conductive hearing loss and adequate cochlear (inner ear) function may be considered on an individual basis. Adequate cochlear function is demonstrated audiologically when stimulation through bone conduction results in significantly improved and functional hearing in the involved ear.

For a child with congenital malformations, sufficient bone volume and bone quality must be present for a successful fixture implantation. Alternative treatments, such as a conventional bone conduction hearing aid, should be considered for a child with a disease state that might jeopardize osseointegration.

## 8400. Updated 10/09

### Bone Anchored Hearing Aid (continued)

#### Replacements

- One replacement BAHA is covered for a KBH beneficiary who meets the initial placement criteria.
- PA is required for all BAHA replacement services. All providers must obtain a PA prior to providing service.
- A replacement processor cannot be billed at the same time as the original processor or the original surgery.
- Replacements are limited to one every four years if lost, stolen, or broken.
- A replacement is not allowed for the purpose of upgrading. A BAHA can only be replaced if the current processor has an expired warranty, is malfunctioning, and cannot be repaired.

#### Dispensing of Hearing Aids

One dispensing fee is covered for binaural and bicros hearing aids.

Fitting of binaural hearing aids are covered, with documentation on the hearing evaluation form, for the following:

- Children under 21 years of age, KBH not required
- A legally blind adult with significant bilateral hearing loss
- A previous binaural hearing aid user
- An occupational requirement for binaural listening

#### Modifiers

Billing for audiology services now requires the use of left (LT) and right (RT) modifiers on all monaural services. If the services are binaural the use of left and right modifiers is not allowed.

#### Explanation of Necessity for Hearing Aids Form

Providers must submit the Explanation of Necessity for Hearing Aids form with the prior authorization request before approval for a replacement hearing aid will be considered. An example of this form is located on the Forms page of the public or secure website (see the Table of Contents and Introduction pages for hyperlinks) ~~in the Forms section at the end of this manual.~~

#### Repairs

Repairs under \$15.00 are **not** covered.

Repairs exceeding \$75.00 must be **prior authorized** (refer to Section 4300 of the *General Special Requirements Provider Manual*). Approval will be given if, in the opinion of the consultant, the repairs are not so extensive that good judgment indicates the fitting and dispensing of a new hearing aid.

Repairs must provide a warranty of six months.

**8400. Updated 10/09**

**Replacements**

Hearing aids may be replaced every four years when a medical examination confirms the necessity.

Lost, broken, or destroyed hearing aids will be replaced **once** with PA during a four-year period. The dispenser and beneficiary must sign a statement documenting the loss, breakage, or destruction of the hearing aid and submit it along with the PA request.

Replacement cords for hearing instruments and cochlear implants are covered with medical necessity documentation.

**Testing and Examination**

Beneficiaries are required to have a medical examination by a physician for pathology or disease. This exam must be provided no more than six months prior to the fitting of a hearing aid and documented on the Explanation of Necessity for Hearing Aids form.

Only enrolled physicians and licensed or certified audiologists will be reimbursed for hearing tests. Certified program for otolaryngology personnel (CPOP) technicians are not allowed to enroll. All services performed by a CPOP technician must be billed through an otolaryngologist.

Basic hearing services can be performed by CPOP technicians under the following guidelines:

- The CPOP technician must be certified by the American Academy of Otolaryngology which includes sponsorship by an otolaryngologist. Certification documentation must be on file in the ear, nose and throat (ENT) facility.
- Services may only be performed in the office of an enrolled ENT specialist.
- The CPOP technician must be directly supervised by an otolaryngologist.
- All CPOP services must be signed off by an otolaryngologist. The otolaryngologist assumes all responsibility for CPOP technicians and services provided.

*Note:* For KAN Be Healthy screening guidelines, see Section 2020 of the *General Benefits Provider Manual*.

**Cardiac Rehabilitation**

Phase II Cardiac Rehabilitation is covered using code 93798. This procedure is covered when performed in an outpatient or cardiac rehabilitation unit setting, with the following criteria:

- Beneficiary must have a recent cardiology consultation within three months of starting the cardiac rehabilitation program.
- Beneficiary must have completed Phase I Cardiac Rehabilitation.
- Beneficiary must have one or more of the following diagnoses/conditions:
  - Acute myocardial infarction (410.00 – 410.92, 414.8) within the preceding three months, post inpatient discharge
  - Coronary bypass (V45.81) surgery within the preceding three months, post inpatient discharge
  - Stable angina pectoris (413.9 and 413.0) within three months post diagnosis

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

## 8400. Updated 04/10

### Children and Family Services (CFS) Contractors

Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to KHPA and will be reimbursed at the approved Medicaid rate. PA and other restrictions apply.

### Community Mental Health Center

When a physician desires to send a beneficiary to a community mental health center (CMHC), he or she should call the center before making this referral. Each center has its own referral requirements and initial appointment procedures and varies in services provided. CMHC services are covered for outpatient treatment and partial hospitalization.

### Consultations

Only one initial consultation is covered within a 60-day period per beneficiary by the same provider.

### CPAP for KBH Participants

Continuous positive airway pressure (CPAP) is a covered service for **KBH participants**. PA for MN is required. For MN, one of the following criteria must be met:

1. Infant Respiratory Distress Syndrome in newborns (e.g., Hyaline Membrane Disease)
2. Morbid obesity with documented sleep apnea
  - 30 percent over average weight for height, sex, and age
  - Sleep study with documented arterial oxygen (O<sub>2</sub>) saturation of 80 percent or less  
*Note:* A printout of the documented arterial O<sub>2</sub> saturation must be supplied by the provider upon request from the fiscal agent and/or KHPA.
  - Documented participation in a weight reduction program  
*Note:* This documentation must be supplied by the provider upon request from the fiscal agent and/or KHPA.

## Dental

### HCBS Adult Oral Health Services

Oral health services are **no longer** available to adults 21 years of age and older who are enrolled in the Home and Community Based Services (HCBS) Mental Retardation/Developmental Disabilities (MR/DD), Traumatic Brain Injury (TBI), and **Physical Disability (PD)** waiver programs. ~~Refer to Exhibit D in the *Dental Provider Manual* for services available for HCBS MR/DD, TBI, and PD adult beneficiaries.~~ For information about covered dental benefits, **reference the *Dental Provider Manual*** or contact Customer Service at 1-800-933-6593.

### Orthodontia

For information about covered orthodontia benefits, **reference the *Dental Provider Manual*** or contact Customer Service at 1-800-933-6593.

## 8400. Updated 04/10

### Developmental Testing

Providers are reimbursed one visit per day up to three visits per beneficiary per year for code 96111.

### Dietitian Services

Dietitian services are covered for **KBH participants** when provided by a registered dietitian licensed through KDHE.

Dietitian services may only be rendered as the result of a medical or dental screening referral. Other insurance and Medicare are primary and must be billed first.

Individual-focused services are limited to two units (30 minutes) of initial evaluation and 11 follow-up visits per beneficiary, per year. Additional visits may be covered with PA.

~~Group focused services are limited to an initial evaluation and 11 follow up visits per beneficiary, per year. Additional visits may be covered with PA.~~ For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp> or from the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations.

### Documentation

To verify services provided in the course of a postpayment review, documentation in the beneficiary's medical record must support the service (level of service) billed. Documentation can be requested at any time to verify that services have been provided within program guidelines. Refer to Section 5000 of the *General Billing Provider Manual*.

### Durable Medical Equipment

Durable medical equipment (DME) items require a written prescription from the physician. In addition, many DME items and medical supplies require PA before they can be dispensed and payment made. Be sure to give the DME provider adequate information and adequate time to secure PA.

Although an item is classified as DME, it may **not** be covered in every instance. Coverage is based on the fact that it is reasonable and necessary for treatment of an illness or injury or will improve the physical functioning of the beneficiary. Medical equipment is primarily used for medical purposes and is not generally useful in the absence of illness or injury.

### Electrocardiograms

Electrocardiograms (EKGs), up to 12 leads, are considered medically necessary when the diagnosis and/or condition clearly indicates one or more of the following:

- Relevant cardiopulmonary diagnosis
- Significant electrolyte imbalance
- Drug induced EKG changes (identify the drug)
- Progressive renal disease
- Unstable thyroid disease

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

## 8400. Updated 10/09

### Electrocardiograms (EKGs) continued

- Specific central nervous system (CNS) disorders causing EKG changes
- Congenital disorders causing EKG changes
- Symptomatic hypothermia
- Shortness of breath
- Fainting spells
- Monitoring the effects of psychotropic drugs for potential cardiac effects (identify the drug)

Preoperative EKGs are medically necessary for patients over 40 years of age or those patients under 40 with a history of cardiac problems.

### Emergency Medical Services for Aliens

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and X-ray services will be allowed for the following places of service: office, outpatient hospital, federally qualified health clinics, state or local public health clinics, rural health clinics, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized. Refer to Section 2040 of the *General Benefits Provider Manual* for specific information.

### Family Planning

Family planning is any medically approved treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.

~~Supplies used during the insertion or removal of Norplant are content of service of the procedure and cannot be billed separately.~~

Planned parenthood clinics must bill family planning services using E&M CPT® procedure codes.

### Hospice

In situations where the attending physician is not operating under contractual arrangement with the hospice, the attending physician will be reimbursed at the regular Medicaid rate for all professional services, including those related to the treatment of the terminal illness without PA. These services include procedure codes which contain a professional component identified with modifier 26, such as lab and X-ray.

### Hospital (Inpatient)

All inpatient stays are subject to utilization review (UR) with the exception of stays involving patients who have Medicare Part A (primary payer). URs are performed on a postpayment basis for general inpatient hospital stays.

Take-home drugs are limited to the amount a patient needs to allow time to get to a pharmacy.

## 8400. Updated 04/10

### Hospital (Inpatient) continued

#### Hospital Visits

- One inpatient hospital visit per provider, per beneficiary, per day is covered.
- A hospital visit and chemotherapy administration to the same beneficiary by the same provider on the same date of service are not covered.
- The **same** provider cannot bill a hospital visit and psychotherapy on the same day for the same beneficiary.
- Only one inpatient follow-up ~~visit consultation~~ is covered within a 10-day period per beneficiary, by the same provider.
- ~~Hospital visits are considered content of service for code 99460.~~

#### Substance Abuse

**Acute detoxification** is covered in any general hospital.

Substance abuse **treatment** is only covered when provided in an intermediate setting.

Substance abuse treatment provided in an intermediate setting (alcohol and drug addiction treatment facility) is limited to three admissions in a beneficiary's lifetime, regardless of provider. (Acute detoxification and day treatment are not included in this limitation.)

### Hospital (Outpatient)

Outpatient services are reimbursed on a fee-for-service basis.

The following are examples of covered outpatient services:

- Emergency room services
- Laboratory services
- Diagnostic or therapeutic radiology services
- Nuclear medicine services
- Outpatient surgery
- Rehabilitative occupational therapy
- Rehabilitative physical therapy

These services should be used for minor surgical or medical procedures which would not require an inpatient stay.

Only one outpatient follow-up consultation is covered within a 60-day period per beneficiary, by the same provider.

The hospital will not be paid for the use of the emergency room when a patient repeatedly abuses emergency room services. Any patient who continually abuses these privileges despite reprimand should be reported to KHPA. (Refer to Section 2400 of the *General Benefits Provider Manual*).

When emergency room services have been determined to be nonemergent, the physician's fee will be reduced to the nonemergency level.

## **8400. Updated 11/03**

### **Emergency Room**

The beneficiary's age and time of admission to an emergency room does not determine emergent status. Conditions relating to the emergency room visit, such as stabilization of an injury or condition, may support the emergent need.

Direct physical attendance by the provider (physician, ARNP, or PA) **must** be documented in the medical record for the visit to be considered emergent.

Phone or standing orders do not support emergency treatment.

Axillary temperatures are not considered accurate and will be disregarded when determining emergent status.

Beneficiaries may go to the emergency room without a referral from their physician based on the definition of an emergency according to a prudent layperson (as defined by the Balanced Budget Act, 1997): What a layperson would consider an emergency in the absence of medical knowledge. Such an emergency could include, but is not limited to: serious impairment to bodily functions; serious dysfunction of any bodily organ or part; severe pain; or an injury/illness that places the health of the individual in serious jeopardy (and in the case of a pregnant woman, her health or that of her unborn child).

### **Other Examples of Emergencies Are:**

- Initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus or other conditions considered "life-threatening"
- Beneficiaries who require transfer to another facility for further emergency treatment or who expire



## 8400. Updated 11/03

### Nonemergent Situations

- Intentional noncompliance with previously ordered medications and treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures/treatments such as drawing blood for laboratory work.
- Leaving the emergency room against medical advice.
- The beneficiary had previously been in the same or different emergency room or physician's office for the same condition and the condition had not worsened.
- Scheduled visits to the emergency room for procedures, examinations or medication administration. Examples include cast changes, suture removal, dressing changes, follow-up examinations and second opinion consultations.
- Visits made to receive a "tetanus" injection in the absence of other emergent conditions.
- Visits made to obtain medication(s) in the absence of other emergent conditions.
- The conditions/symptoms relating to the visit had been experienced longer than 48 hours or are of a chronic nature and emergency medical treatment to stabilize the condition was not required.
- A referral is necessary for all nonemergent services when treating a HealthConnect beneficiary.

**The following conditions will not be considered emergent unless the criteria described has been met:**

Alcoholism: An acute medical/surgical condition exists (e.g., gastric bleeding, dehydration).

Depression/Anxiety: Documentation must support the beneficiary to be an immediate danger to self or others.

Fever: Documented fever in the emergency room of 103° Fahrenheit (39.5° Celsius) or above rectally in children and of 102° Fahrenheit (38.9° Celsius) or above orally in adults.

**8400. Updated 11/03**

Insect Bites and Stings/Embedded Ticks: Documentation must support the presence of complications resulting from the bite/sting beyond the expected local reactions such as redness, itching or swelling.

Minor Burns/Sunburns: Documentation must support presence of complications such as severe swelling, infection or the young age of the beneficiary. Eye and chemical burns are considered emergent.

Otitis Media - not emergent unless:

- The tympanic membrane is bulging or ruptured.
- There is drainage from the ear(s).
- Documented fever in the emergency room of 103° Fahrenheit (39.5° Celsius) or above rectally in children and of 102° Fahrenheit (38.9° Celsius) or above orally in adults.
- The beneficiary is age three or under and is crying inconsolably.
- The physician's examination documents the presence of acute otitis media and there is no access to a physician's office due to holiday or weekend or is after office hours.

Removal of Cutaneous Foreign Bodies: Sedation or the use of extensive medical supplies were required for the removal of the foreign body (e.g., splinters, cactus needles).

Seizures - not emergent unless:

- The condition was previously undiagnosed and the visit was following or during a seizure.
- A secondary disorder/diagnosis exists (e.g., hypoglycemia, infection, etc.).
- The beneficiary is 12 years of age or younger.
- The beneficiary was brought in by the police and the condition was unknown.
- The beneficiary was in status epilepticus.
- The beneficiary is in an epileptic state aggravated by alcohol/drug ingestion.

Skin Rash/Hives: Documentation must support presence of systemic complications beyond the local skin discomforts resulting from the rash. If the rash causes eye complications or the patient has a history of anaphylactic (allergic) reactions, the visit is considered emergent.

## 8400. Updated 11/03

### Observation Room

Observation is a service which requires monitoring a patient's condition. Examples of the appropriate use of the observation room may include:

- Monitoring head trauma
- Drug overdose
- Cardiac arrhythmias
- False labor

A physician, physician assistant (PA), or ARNP must see the patient within two hours **prior** to admission to the observation room except for obstetrical labor or scheduled administration of IV medication or blood products. The observation room stay must be medically necessary.

There is no time limit restriction for the observation room. The same reimbursement rate applies regardless of the number of hours required for monitoring. Reimbursement is all inclusive of services and supplies. If there is a discharge and readmission to the observation room from midnight to midnight, only one reimbursement rate will be allowed.

The following examples are considered content of service of the observation room and will not be reimbursed separately:

- Minor surgery
- Recovery room services following inpatient or outpatient surgery
- Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.
- **Scheduled and nonscheduled** fetal oxytocin stress tests and fetal nonstress tests
- ER physician fee

### **Hospital (Psychiatric)**

Inpatient psychiatric admissions are covered only after a psychiatric preadmission assessment has been completed and a determination made that the most appropriate treatment setting is the hospital. No payment will be made for the hospital admission or related physician services without the completion of the preadmission assessment and determination that the hospital admission meets criteria. When seeking to admit a Kansas Medical Assistance Program beneficiary for inpatient treatment call **1-800-466-2222** to arrange for the assessment to be completed. This toll-free number is staffed 24 hours a day by the Mental Health Consortium (MHC).

## **8400. Updated 11/03**

After receiving a request for a psychiatric preadmission assessment the MHC will contact the appropriate Community Mental Health Center (CMHC) or other approved provider if the admission is out-of-state to complete the assessment face-to-face with the Kansas Medical Assistance Program beneficiary. Following completion of the assessment, the hospital and admitting physician will be notified of the results verbally and via a letter from the MHC. If the admission was approved a prior authorization (PA) number will be included in the letter for the hospital and physician to utilize when billing for the approved admission and related services.

The primary care physician's referral is not required for psychiatric hospital stays or related physician and ancillary services provided during the psychiatric hospitalization approved through the preadmission assessment process.

### **Emergency Psychiatric**

Screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric care. The individual is in crisis and not currently in a place of safety. A screening is completed immediately (no later than three hours) to determine appropriate placement.

### **Urgent Psychiatric**

Screening is initiated if the individual meets one of the four independent criteria and is currently in a place of safety. An observation bed may be used to provide security and “observation” for individuals in imminent danger and to assist in the determination of the need for psychiatric hospitalization. In this instance, the screening must be completed as soon as possible and within two days of the Consortium’s receipt of the request.

### **Planned Psychiatric**

Noncrisis in nature, the screening must be completed within two days of the Consortium’s receipt of the request. The admission must occur within two days of the completion of the screening.

### **Retroactive Psychiatric**

Individuals whose Medicare or other primary insurance denied payment for treatment, and who were Medicaid eligible at the time of admission. Other retroactive screens may be authorized for denied requests when eligibility is in question. If the individual receives a valid Medicaid card after a hospital admission has been completed, the Consortium requests the admission information and completes a pre-admission screening within five working days of the receipt of that information.

## 8400. Updated 11/03

### Group/Individual Psychotherapy

Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, **group** psychotherapy is not covered when provided by psychologists, physicians or CMHCs in a hospital setting. **Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.**

Psychotherapy is not covered on days electroshock is given.

A maximum of 12 inpatient electroshock treatments per month are covered.

### Psychiatric Observation Beds

Outpatient psychiatric observation beds are covered for up to two consecutive days. During the observation period, the patient must receive a physical examination along with a history of psychiatric assessment which contains recommendations for ongoing treatment. An initial nursing assessment must be completed and nursing progress notes written for each shift. A discharge summary must be completed when the patient is discharged.

A physician must admit the patient to an observation bed and discharge the patient at the end of the observation stay. When an admission follows an observation stay, the physical examination report and the psychiatric assessment must be included in the patient's medical record.

The physical examination and preadmission assessment must be billed by the provider of the service.

### Crisis Resolution Services

Hospitals may be reimbursed when Medicaid patients are admitted to observation/stabilization beds for crisis resolution services in accordance with the following conditions:

- The patient is referred by the primary care case manager, agency, or health professional currently providing care (whichever is applicable).
- The patient shall have demonstrated an acute change in mood or thought that is reflected in behavior, indicating the need for crisis intervention to stabilize and prevent hospitalization.
- The patient must have a diagnosed psychiatric disorder.
- The patient must not be in need of acute detoxification or withdrawal symptoms.
- The patient must be medically stable.
- The following documentation shall be completed: nursing assessment (including physical review, mental status, and medication), strength assessment, a personal crisis plan, and at least one progress note.

Crisis resolution services are covered up to two consecutive days.

## **8400. Updated 11/09**

### **Hyperbaric Oxygen Therapy**

Hyperbaric oxygen therapy is covered under KMAP with PA. The following criteria must be met before a PA will be approved.

1. The services must be for one of the following conditions:
  - a. Acute carbon monoxide intoxication
  - b. Decompression illness
  - c. Gas embolism
  - d. Gas gangrene
  - e. Acute traumatic peripheral ischemia
  - f. Compromised skin grafts
  - g. Chronic refractory osteomyelitis
  - h. Osteoradionecrosis
  - i. Soft tissue radionecrosis
  - j. Cyanide poisoning
  - k. Actinomycosis
  - l. Crush injuries and suturing of severed limbs
  - m. Progressive necrotizing infections
  - n. Acute peripheral arterial insufficiency
  - o. Diabetic wounds of lower extremities
2. It must be documented that other treatments have been attempted with no improvement.

Physicians bill for this procedure using 99183 (one unit equals one treatment session). If there are multiple sessions on the same day (more than one unit for physicians), each subsequent session must be billed on a separate detail line with modifier 76.

### **Immunizations/Vaccines**

Reimbursement for covered immunizations for children is limited to the administration fee. Vaccines are supplied at no cost to the provider through Vaccines for Children, a federal program administered by KDHE.

Codes 90470 and G9141 are covered for the administration of the H1N1 vaccine. These codes are covered for all benefit plans, except for beneficiaries who only have ADAPD coverage, with a reimbursement rate of \$14.15. Claims for the administration of the H1N1 vaccine should be billed with diagnosis code V04.81 (H1N1). Since the H1N1 vaccine is available at no cost to providers, payment is not being issued for 90663 or G9142. If providers are interested in administering the H1N1 vaccine, they can contact KDHE to receive the vaccine.

**8400. Updated 11/09**

**Injections of B12**

Vitamin B12 injections are covered only when one or more of the following diagnoses are present:

- |                            |   |
|----------------------------|---|
| Anemia, fish, tapeworm     | Friedreich's ataxia; post lateral sclerosis |
| Anemia, iron deficiency    | Hepatic Diseases or Dysfunctions            |
| Anemia - Addison's         | Malignant and benign neoplasms              |
| - Biermer's                | Neuropathies of malnutrition and alcoholism |
| - Macrocytic               | Renal Disease                               |
| - Megaloblastic            | Sprue, Short Gut Syndrome, Short            |
| - Pernicious               | Bowel Syndrome                              |
| Crohn's Disease, Ileitis - | Strictures of Intestines                    |
| chronic or regional        | Whipples Disease                            |
| Chronic Enteritis/Colitis  |   |
| Dumping Syndrome,          |   |
| Jejunal Syndrome           |   |

**Intrathecal Baclofen Pump**

Intrathecal baclofen pumps are covered for Medicaid beneficiaries. This includes the initial and all subsequent implantation(s), revision(s), repairs, catheters, batteries, refills, removals, and maintenance of the intrathecal baclofen pumps when indicated. Three services require PA: 62350, 62351, and 62362. The following conditions must be met:

- The beneficiary must have responded favorably to a trial of intrathecal baclofen and include documentation of previously used medication.
- The beneficiary's ICD – diagnosis code must be a covered code and the source of the spasticity must be documented.
- The beneficiary must be over the age of four years, or there must be documentation that there is sufficient space within the child's chest wall for the pump to be implanted.

Contraindications include pregnancy and active infection at time of surgery.

Procedure codes 62311, 62319, 62355, 62365, 95900, 95991, and 62368 do not require PA, but a HCK beneficiary does need a referral from his or her PCP.

**Laboratory**

Only the provider performing the laboratory analysis shall bill.

When ordered laboratory tests make up a panel or profile the all-inclusive procedure code should be used to bill; do not bill each component separately.

A drawing or collection fee is considered content of service of an office visit or other procedure and is not covered if billed separately. The beneficiary cannot be billed for the drawing or collection since it is considered content of another service or procedure.

Do **not** bill Medicaid for laboratory services referred to an outside laboratory. The laboratory will bill Medicaid directly for their services.

## 8400. Updated 11/09

### Laboratory continued

Laboratory procedures performed on **inpatients** are content of service of the DRG reimbursement to the hospital and should not be billed by an independent laboratory.

Pathologists **not** contracted by a hospital may bill the professional component (modifier 26) on pathology services provided on inpatients.

Reimbursement will only be made for one complete blood count (CBC) per day. KMAP considers three or more multichannel tests to be a SMA/SMAC, or profile, when performed on the same date of service. Medicaid follows the guidelines outlined in the *CPT*<sup>®</sup> codebook to identify automated multichannel tests (SMACs, profiles). When billing for a multichannel test use the appropriate *CPT*<sup>®</sup> procedure code (organ or disease oriented panels).

Cytogenetic (chromosome) studies are covered for **pregnant women** (when medically necessary) and **KBH** participants only. A medical necessity form must accompany the claim when billing for a cytogenetic study for a pregnant woman over 21 years of age.

The following HIV testing is limited to four per calendar year, regardless of provider. Refer to the *CPT*<sup>®</sup> codebook for complete description of these procedures: 86689, 86701, 86702, 86703, 87390, 87391, 87534, 87535, 87537, 87538, 87539, 87900, 87903, 87904.

Code 87536 is covered.

Code 87901 is covered. Medical necessity documentation must include information that the patient meets at least one of the following criteria:

1. The patient presents with virologic failure during Highly Active Antiretroviral Therapy (HAART).
2. The patient has suboptimal suppression of viral load after initiation of antiretroviral therapy.

**Note:** For 87901 only, testing is limited to two per calendar year.

Code 87902 is also covered.

### Local Education Agency (LEA) Services

Providers of LEA services shall have appropriate credentials from the Kansas State Department of Education. Refer to the *Local Education Agency Provider Manual* for a complete list of covered services.

### Maternity Center Services

Labor and delivery in a maternity center setting is covered for Medicaid and MediKan beneficiaries. Maternity centers must be licensed by the State of Kansas (or equivalent if located in another state) and enrolled as a provider in KMAP. Reimbursement is on a fee-for-service basis. Maternity center services are exempt from beneficiary copayment. Supplies are content of service of labor and delivery charges. The physician is responsible for billing his or her charges for care provided.



## **8400. Updated 11/09**

### **Mid-Level Practitioners**

All services performed by physician assistants (PAs) or ARNPs within the scope of their license are covered with the same limitations that apply to physician services. Specific limitations are defined in the ARNP section of this manual.

### **Nursing Facility (NF)**

Bill code 99318 when providing a routine annual history and physical examination.

If the NF resident is seen for medical reasons other than what can be billed under 99318, the appropriate code(s) should be used. If the resident is Medicare eligible, bill Medicare first.

### **Obstetrical (OB) and Gynecological**

The following procedures are content of service of total OB care:

- Office visits (nine months before and six weeks after delivery)
- Urinalysis
- Internal fetal monitor

Total OB care generally consists of 13 office visits, delivery (vaginal or cesarean), and postpartum care. The provider of total OB care should bill codes 59400 or 59510 whichever applies. If an ARNP or PA provides part of the prenatal care but does not deliver the baby, the physician may bill the global fee without indicating the PA or ARNP as the performing provider. If the ARNP or PA provides part of the prenatal care and delivers the baby, the services must be broken out and the PA or ARNP indicated as the performing provider. Providers should **not** bill for OB services until care is completed (for example, the beneficiary delivers, or the beneficiary is no longer a patient).

When a provider does **not** complete total OB care, and only **partial** antepartum care has been provided, the following guidelines apply when billing services:

**One to three prenatal visits only** - Bill using E&M office visit codes.

**Four to six prenatal visits only** - Bill using code 59425. This code must NOT be billed by the same provider in conjunction with one to three office visits, or in conjunction with code 59426.

**Complete antepartum care without delivery** - Bill using code 59426. Complete antepartum care is limited to one beneficiary pregnancy per provider.

**Delivery only** (no antepartum care provided) - Bill using code 59409 or 59514.

**8400. Updated 04/10**

**Obstetrical (OB) and Gynecological continued**

**Delivery and postpartum care only** - Bill using code 59410 or 59515.

**Codes 59425 and 59426** may be billed only once per provider, per beneficiary pregnancy. These codes must not be billed together by the same provider for the same beneficiary, during the same pregnancy.

Pregnancy-related (E&M) office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same beneficiary, during the same pregnancy.

Fetal oxytocin stress testing (initial or subsequent) is not covered in place of service 21 (inpatient).

Fetal nonstress test (electronic, external fetal monitor applied) is not covered in place of service 21 (inpatient).

Code 59426 is limited to one per pregnancy, per provider.

Only one IUD insertion every seven days per beneficiary is covered.

**Obstetrical Pelvic Sonograms**

One routine sonogram will be covered per fetus per pregnancy using the diagnoses V220-V222. A routine OB sonogram will not be covered if the sonogram is performed solely to determine the fetal sex or to provide parents a view and photograph of the fetus.

Primary diagnosis must support medical necessity for an OB sonogram. Some examples are: **indication of** vaginal bleeding, multiple birth, diabetes, size/date discrepancy, fetal anomalies, threatened abortion, placental/uterine abnormalities, fetal demise, maternal drug/alcohol/tobacco use, or **history of** previous miscarriage, cesarean section, stillbirth, ectopic pregnancy, eclampsia, or intra-uterine growth retardation.

Medical necessity may also be determined based on maternal age, maternal weight, or fetal position. If applicable, this information should be submitted with the claim.

**Office Visits**

One comprehensive office visit per calendar year per beneficiary is covered.

E&M office visit procedure codes 99201-99205 may be used for any new patient or any patient that has not been seen by the provider within the past three years.

School or employment physicals should be billed using an E&M office visit procedure code.

An office visit billed on the same day as chemotherapy administration, cast application, or an IUD removal by the same provider for the same patient is not covered.

## 8400. Updated 04/10

### Oxygen Therapy

All oxygen equipment (stationary and portable), supplies, and accessories must be supplied by the same provider. Only one provider can bill for these services at a time.

All claims for monthly rental items must be billed using appropriate date ranges.

- Claims must range from the first day of service through the last day of service for the month being billed. (One unit equals one month/30 days.)
- Claims billed using the same date for the beginning and the ending dates will be denied.
- If a beneficiary changes providers, the dates billed by the previous provider and the new provider cannot overlap.

Once a beneficiary no longer requires oxygen services, it is the responsibility of the DME provider to obtain a discharge order from the physician or have the beneficiary sign a medical release of liability form and immediately pick up all equipment. All rented oxygen systems must be billed using modifier RR. DME suppliers cannot bill the KHPA Medical Plans or the beneficiary for equipment left in the home unused.

If a beneficiary wants to switch providers, it is the DME supplier's responsibility to obtain a physician's order or a medical records release signed by the beneficiary. It is the responsibility of both DME suppliers to coordinate delivery and pick-up of the equipment with each other. The new provider cannot bill the KHPA Medical Plans until he or she has a pick-up ticket from the old company to prove he or she is the new supplier. The new supplier must obtain a new certificate of medical necessity signed by the physician and have it on file at all times.

### COVERAGE CRITERIA

Home oxygen is covered if the beneficiary meets all of criteria 1-5 and at least one of criteria 6-9.

1. The treating physician has diagnosed the beneficiary with a severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen.
2. The beneficiary meets the laboratory values listed under the following section, Qualifying Laboratory Value Requirements.
3. The qualifying laboratory values were performed by a physician or qualified provider of laboratory services.
4. The qualifying laboratory values were obtained under either of the following conditions:
  - If the qualifying laboratory value is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to, the hospital discharge date.
  - If the qualifying laboratory value is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state not during a period of acute illness or an exacerbation of their underlying disease.

**8400. Updated 04/10**

**Oxygen Therapy continued**

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.
6. Beneficiary has an arterial PO<sub>2</sub> at or below 55 mm Hg or arterial oxygen saturation at or below 88 percent taken at rest (awake).
7. Beneficiary has an arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent for at least five minutes during sleep with an arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 88 percent while awake.
8. Beneficiary has a decrease in arterial PO<sub>2</sub> more than 10 mm Hg or a decrease in arterial oxygen saturation more than 5 percent for at least five minutes during sleep and associated symptoms or signs reasonably attributable to hypoxemia (such as cor pulmonale, “P” pulmonale on EKG, documented pulmonary hypertension and erythrocytosis).
9. Beneficiary has an arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent during exercise with an arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest lasting at least five minutes. *In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia demonstrated during exercise when the beneficiary was breathing room air.*

Oxygen therapy is not covered in the following conditions:

- Angina pectoris in the absence of hypoxemia  
*Note: This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.*
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia  
*Note: There is no evidence that increased PO<sub>2</sub> will improve the oxygenation of tissues with impaired circulation.*
- Terminal illnesses that do not affect the respiratory system
- Beneficiaries enrolled in any type of clinical trial
- Treatment of sleep apnea (when medical necessity indicates a CPAP machine is needed but oxygen is being used instead)
- Back-up oxygen  
*Note: Back-up is considered extra equipment in case one fails; extra refillable tanks stored for use when one runs out is not considered back-up.*
- Oxygen furnished by an airline
- Any place of service other than home (such as skilled nursing facility [SNF], nursing facility [NF], psychiatric residential treatment facility [PRTF], intermediate care facility for mental retardation [ICF/MR], or hospital)
- Stand-by or emergency (oxygen in place just in case something happens) oxygen for beneficiaries who do not have severe lung disease  
*Note: Acute infections/episodes are not considered severe lung disease.*

**8400. Updated 04/10**

**Oxygen Therapy continued**

**QUALIFYING LABORATORY VALUE REQUIREMENTS**

The term “qualifying laboratory value” refers to either an arterial blood gas (ABG) test or an oximetry test. An ABG is the direct measurement of the partial pressure of oxygen (PO<sub>2</sub>) on a sample of arterial blood. The PO<sub>2</sub> is reported as mm Hg. An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percentage.

If a beneficiary is receiving home oxygen prior to May 1, 2010, and has a current qualifying laboratory value that was performed and on file with the DME provider between November 1, 2009, and May 1, 2010, a new laboratory value will not be required until November 1, 2010. All beneficiaries must meet new laboratory value requirements on November 1, 2010. Beneficiaries with a laboratory value performed and on file prior to November 1, 2009, will be required to have a new laboratory value performed and on file starting May 1, 2010.

When both ABG and oximetry tests have been performed on the same day under the same conditions (such as at rest [awake], during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test at rest (awake) is nonqualifying, but an exercise oximetry test on the same day is qualifying, the oximetry test result will determine coverage.

The qualifying laboratory value must be performed by a provider who is qualified to bill Medicaid for the test (Part A provider, laboratory, independent diagnostic testing facility [IDTF]) or a physician. A DME supplier is not considered a qualified provider or a qualified laboratory. Laboratory value studies performed by a supplier are not acceptable. In addition, the qualifying laboratory value cannot be paid for by any DME supplier.

When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three oxygen studies in the beneficiary’s medical record (testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied demonstrating the improvement of the hypoxemia). All results must be maintained in the beneficiary’s file with the DME provider.

Qualifying laboratory value studies must be performed annually (every three months for acute conditions) for all beneficiaries, and they must continue to meet all criteria. The DME provider must maintain all results in the beneficiary’s file. When a physician orders to extend oxygen coverage, a repeat qualifying blood gas study must be performed within 30 days prior to the date of extension, and the beneficiary must continue to meet criteria.

For a beneficiary with acute, short-term conditions (for example, bronchitis or pneumonia) a new qualifying laboratory value and a new physician’s order must be obtained prior to initiation of oxygen and every three months following. The beneficiary must continue to meet oxygen criteria. Once the beneficiary no longer meets oxygen criteria, providers are to cease billing the KHPA Medical Plans.

## 8400. Updated 04/10

### Oxygen Therapy continued

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. The physician's order or prescription must include: diagnosis, flow rate, frequency, and estimated duration. A generic prescription only stating "Oxygen PRN" is not acceptable.

### CERTIFICATION

A Certificate of Medical Necessity – Oxygen form which has been completed in its entirety, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. All providers must use the CMS-484 Certificate of Medical Necessity – Oxygen form. This form must be completed in its entirety according to the Centers for Medicare and Medicaid Services (CMS) instructions and be in the beneficiary's file at all times. According to CMS instructions, Section B of this form cannot be completed by the DME supplier. A new, updated form must be completed each time a beneficiary's oxygen needs change. This form must be updated no less than every 12 months. The form can be found on the CMS website at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp>.

For initial certifications, the laboratory value study must be the most recent study which is no more than 30 days prior to the first day of oxygen use.

#### Initial CMNs are required:

- With the first claim for home oxygen (even if the beneficiary was on oxygen prior to Medicaid eligibility or oxygen was initially covered by another entity)
- When there has been a change in the beneficiary's condition causing a break in medical necessity of at least 60 days plus the remaining days in the rental month during which the need for oxygen ended
- When there is a change of supplier

#### Recertification CMN is required:

- 12 months after the initial certification and every 12 months following for all beneficiaries
- For short-term acute conditions, initial certification and every three months following until oxygen is discontinued

**Note: Beneficiary must be seen and re-evaluated by the treating physician within 90 days prior to the date of recertification.**

#### A revised CMN is required:

- When portable oxygen systems are added
- When a stationary system is added subsequent to a portable system
- When the length of need expires
- When there is a new treating physician
- When there is a change from one type of system to another (such as concentrator, liquid, or gaseous)

## **8400. Updated 04/10**

### **Oxygen Therapy continued**

#### **STATIONARY OXYGEN SYSTEMS**

A stationary oxygen system is covered if the beneficiary meets oxygen criteria. All stationary oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one month rental). All supplies, repairs, maintenance, and contents are considered content of the rental and are not reimbursed separately. A system is considered beneficiary-owned if the ownership of the entire system has been previously transferred to the beneficiary. For those beneficiary-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

#### **PORTABLE OXYGEN**

A portable oxygen system is covered if the beneficiary meets oxygen criteria, is mobile within the home, and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is noncovered. If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the beneficiary uses.

All portable oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one month rental). All supplies, repairs, maintenance, and contents are considered contents of the rental and are not reimbursed separately. A system is considered beneficiary-owned if the ownership of the entire system has been previously transferred to the beneficiary. For those beneficiary-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

#### **OXYGEN CONTENTS**

Stationary and portable oxygen contents are payable separately only when the coverage criteria for home oxygen have been met, and they are used with a beneficiary-owned stationary gaseous or liquid system respectively. One unit equals a one month supply.

#### **ACCESSORIES**

All oxygen accessories, parts, and supplies are included in the allowance for rented oxygen systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when used with a beneficiary-owned oxygen system. Kansas Medicaid limitations will apply.

#### **DELIVERY, MAINTENANCE AND REPAIRS**

All delivery charges are content of service and cannot be billed separately. The DME supplier can deliver no more than a three-month supply at a time. The DME supplier is responsible for all delivery and pick up of oxygen and supplies for all oxygen systems and services. The DME supplier is responsible for maintenance and repairs. All maintenance and repairs of rented systems are considered content of service and cannot be billed separately. Maintenance and repair of beneficiary-owned systems requires prior authorization. Routine maintenance on beneficiary-owned systems will be allowed no more than once every six months with PA.

## 8400. Updated 04/10

### Oxygen Therapy continued

After the initial study, either a blood gas or oximetry study is required annually. The prescription and blood gas levels must be dated prior to the service date, retained in the provider's files, and provided upon request. Oxygen need determination is based on hypoxemia. Hypoxemia is defined as a PaO<sub>2</sub> arterial blood gas level of less than 60mm Hg or oximetry saturation of 85 percent or less. Patients who cannot be removed from oxygen for laboratory studies and whose hypoxemia is not documented require signed statements from two physicians, preferably one being a pulmonary specialist, documenting the effects of oxygen supply removal on the beneficiary. These statements must be retained in the provider's files and provided upon request. Neonates with bronchopulmonary dysplasia whose hypoxemia cannot be documented require a signed letter from a physician, preferably a neonatologist, documenting the patient's condition and prognosis. This letter must be retained in the provider's files and available for review by the medical staff upon request.

The Home Oxygen Informational Form can be found on the Forms page of both the public and secure websites (see the Table of Contents and Introduction pages for hyperlinks) section of this manual. Photocopies for your use may be made directly from this page.

*Note:* Additional information may be added to the face of your claim if necessary. Electronic billers who have had initial billings denied with EOB 548 (Service denied. This claim and all attachments have been reviewed by the medical staff and the medical necessity of the service rendered is not supported by the documentation provided) may resubmit a paper claim with the necessary documentation noted on the face of the claim. If the claim and/or attachments do not support medical necessity, the service will be denied.

### Pain Management

Providers are encouraged to use the Pain Management Guidelines developed by The Federation of State Medical Boards of the United States, Inc. and adopted by the Adult and Medical Services Commission. The guidelines are the following:

#### Evaluation of the Patient

- A complete medical history and physical examination must be conducted and documented in the medical records.
- The medical records should document the nature and intensity of the pain, evaluate underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse.
- The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

#### Treatment Plan

- The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned.
- After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.



**Pain Management continued**

**Informed Consent and Agreement for Treatment**

- The physician should discuss the risks and benefits of the use of controlled substances with the patient, significant other(s) or guardian.
- The patient should receive prescriptions from one physician and one pharmacy where possible.
- If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including:
  - Urine/serum medication levels screening when requested
  - Number and frequency of all prescription refills
  - Reasons for which drug therapy may be discontinued (i.e. violation of agreement)

**Periodic Review**

- At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology of the pain.
- Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living and quality of social life.
- If reasonable treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued opioid treatment.
- The physician should monitor patient compliance in medication usage and related treatment plans.

**Consultation**

- The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives.
- Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion.
- The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

**Medical Records**

- The physician should keep accurate and complete records to include:
  - Medical history and physical examination
  - Diagnostic, therapeutic and laboratory results
  - Evaluations and consultations
  - Treatment objectives
  - Discussion of risks and benefits

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

**8400. Updated 04/10**

**Pain Management continued**

- Treatments
- Medications (including date, type, dosage, and quantity prescribed)
- Instructions and agreements
- Periodic reviews
- Records should remain current, be maintained in an accessible manner, and be readily available for review.

**Compliance with Controlled Substances Law and Regulations**

- To prescribe controlled substances, the physician must be licensed in the state of Kansas, have a valid controlled substances registration, and comply with federal and state regulations for issuing controlled substances prescriptions.
- Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration (and any regulations issued by the State Medical Board) for specific rules governing issuance of controlled substance prescriptions as well as applicable state regulations.

**Definitions**

For the purposes of the pain management guidelines for Kansas Medicaid, the following terms are defined as follows:

Acute Pain - Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time limited and is responsive to opioid therapy, among other therapies.

Addiction - Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Chronic Pain - A pain state that is persistent and in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Physical Dependence - Physical dependence is a physiologic state of neuroadaptation to an opioid which is characterized by the emergence of a withdrawal syndrome if the opioid use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by readministration of the opioid. Physical dependence appears to be an inevitable result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance Abuse - Substance abuse is the use of any substance(s) for nontherapeutic purposes, or use of medication for purposes other than those for which it is prescribed.

Tolerance - Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

**8400. Updated 04/10**

**Patient Demand Cardiac Monitoring**

Patient Demand Cardiac Monitoring is covered in the following situations:

- Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30-day period of time; includes transmission, physician review and interpretation
- Patient demand single or multiple event recording with presymptom memory loop, per 30-day period of time; recording includes hook-up, recording, and disconnection
- Patient demand single or multiple event recording with presymptom memory loop, per 30-day period of time; monitoring, receipt of transmissions and analysis
- Patient demand single or multiple event recording with presymptom per 30-day period of time; physician review and interpretation only

**Pharmacy**

**DAW DOCUMENTATION REQUIRED.**

In order for KMAP to increase patient safety, unnecessary expenditures, and assist in monitoring drug products, if a prescriber specifies dispense as written (DAW) on a drug which has a bioequivalent generic substitute available, the prescriber will be required to fill out the FDA MedWatch form 3500. This MedWatch form must be submitted to the dispensing pharmacy AND also to the FDA. The dispensing pharmacy will then submit this to the KMAP Prior Authorization unit for evaluation and receive approval if medical necessity is met.

**Submitting MedWatch documentation for review:**

The FDA MedWatch forms can be obtained online at <http://www.fda.gov/medwatch/getforms.htm>.

- Prescribers must mail or fax the completed FDA MedWatch forms to the FDA AND to the dispensing pharmacy.

**Address** MedWatch  
5600 Fishers Lane  
Rockville, MD 20852-9787

**Fax** 1-800-FDA-0178

- Pharmacists must mail or fax the completed FDA MedWatch forms to the KMAP Prior Authorization department for consideration. Please include the following information when mailing or faxing the FDA MedWatch forms:

- Pharmacy name
- Pharmacy phone and fax numbers
- KMAP provider number

**Address** Kansas Medical Assistance Program  
P.O. Box 3571  
Topeka, KS 66601-3571  
Attn: Prior Authorization

**Fax** 1-800-913-2229 or 785-274-5956

- The Prior Authorization department will contact the pharmacy to inform them of the status of the DAW request.

**8400. Updated 04/10**

**Pharmacy continued**

**CRITERIA TO MEET MEDICAL NECESSITY FOR A BRAND NAME DRUG WHEN A BIOEQUIVALENT GENERIC SUBSTITUTE IS AVAILABLE**

**A. Adverse reaction(s) to the generic:**

Documentation by prescriber that the adverse reaction caused by the generic meets one of the following criteria:

1. Life threatening
2. Hospitalization
3. Disability
4. Required intervention to prevent impairment or damage

**OR**

**B. Allergic reaction(s) to the generic:**

Prescriber must document the beneficiary's experience of an allergic reaction to the generic product of one or more manufacturers. The dates and clinical details with the name of specific companies and the generic versions involved must be included.

**OR**

**C. Therapeutic failure(s) of the generic:**

Prescriber must document the clinical failure due to beneficiary's suboptimal drug plasma concentration while taking the generic drug when compared to published full pharmacokinetic profiles for the brand name drug.

The term "generic drug" means a drug that is "bioequivalent." Kansas law refers to the Federal Food and Drug Administration's definition, which says drugs are bioequivalent if:

- 1) They use the same active ingredient as the original version of the drug.
- 2) The active ingredient is absorbed and available where it is needed in the body at the same rate.

**Prior Authorization**

Some medications require PA before they can be dispensed and payment made to the pharmacy provider. A staff member may contact you for a patient diagnosis or laboratory data to justify the authorization. Approved PAs will have a specified duration, not to exceed one year.

The KMAP PA and PA criteria forms can be viewed and downloaded at:

<http://www.khpa.ks.gov/pharmacy/default.htm>

## 8400. Updated 04/10

### Pharmacy continued Preferred Drug List

The 2002 Legislature passed a law (Kan. Session. L., 200, c.180) permitting Kansas Medicaid to implement a preferred drug list (PDL). The Medicaid department convened an advisory committee of practicing physicians and pharmacists to evaluate drugs in therapeutic drug classes for clinical equivalence and to make recommendations to the Kansas Department of Social and Rehabilitation Services (SRS) and to the Drug Utilization Review (DUR) Board. Using a PDL will promote clinically appropriate use of drugs in a cost-effective manner. Prescriptions for the nonpreferred drugs will require PA. As other therapeutic drug classes are evaluated by the PDL Advisory Committee and the DUR Board, KMAP will publish this information to providers.

The PDL KMAP coverage list(s) and their corresponding PA request forms can be viewed and downloaded at:

<http://khpa.ks.gov/MedicalAssistanceProgram/PharmacyInformation/default.html>

### Days Supply

A 31-day supply of medication per prescription is the **maximum** that may be prescribed and dispensed at one time for medications covered by the program. Refills will be covered only for those drugs which are refillable, as indicated by the ordering physician, and per Kansas pharmacy law. KMAP will only allow a refill after 80 percent of the prescription has been used.

### Drug Efficacy Study Implementation

All drugs classified as Drug Efficacy Study Implementation (DESI), less-than-effective drugs and their Identical, Related, and Similar (IRS) drugs are noncovered by KMAP.

### Legend/Over-the-Counter (OTC) Drugs

Most legend drugs are covered for Medicaid beneficiaries. Some over-the-counter (OTC) products are covered with a prescription. Legend prenatal vitamins are covered for pregnant females only and up to three months postpartum for lactating women.

### Drug Restrictions

To view KMAP drug restrictions, access the *Pharmacy Provider Manual* from the public website at <https://www.kmap-state-ks.us/Public/Provider.asp>. Click **Manuals** and select Pharmacy from the Manual Type list box. Drug limitations are listed under Benefits and Limitations, Section 8400.

### Prosthetic and Orthotic Devices

The prosthetic or orthotic device **must** be necessary and appropriate for the treatment of the patient's illness or injury, or replace or improve the functioning of a body part.

Prosthetic devices are covered when:

- The device is ordered by a physician and supplied by a prosthetic and orthotic provider enrolled in KMAP.
- The device will replace all or part of the external body members.

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

**8400. Updated 04/10**

**Prosthetic and Orthotic Devices continued**

Repairs or replacements are covered.

Orthotic devices are covered when:

- Ordered by a doctor
- Serve in the treatment of the patient's illness
- Improve the functioning of a body part

**Psychiatric**

Outpatient psychotherapy (individual, group, family) will not be covered for KMAP beneficiaries when provided by the same provider within the same quarter as partial hospitalization activity **and** targeted case management services, except for brief therapy for crisis or continuing evaluation purposes. If more than six hours of individual, group, or family therapy are billed in the same quarter a Certificate of Medical Necessity form must be completed and attached to the claim. Medical necessity (MN) is defined as the individual exhibiting behavior that is dangerous to himself/herself or others, and without additional therapy inpatient hospitalization would be required.

Individual therapy is limited to 32 hours per calendar year for beneficiaries not participating in the KBH program. 40 hours of individual therapy per calendar year are allowed for KBH beneficiaries.

Group therapy or a combination of group and family therapy is limited to 20 hours per calendar year, per beneficiary, regardless of provider. 40 hours of group or family therapy (or a combination of these) are allowed per calendar year for KBH beneficiaries.

KBH beneficiaries continue to be eligible for outpatient psychotherapy (individual, group, family), targeted case management, and partial hospitalization services concurrently.

Six electroshock treatments per month are covered. Psychotherapy is not covered on days that electroshock treatment is given.

Mental health services to beneficiaries residing in a nursing facility for mental health will be noncovered. Exception will be made for up to eight hours of therapy for code 90806 for individuals in acute trauma and for targeted case management and community psychiatric supportive treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are code 90801 and psychiatric preadmission assessments which require no special approval.

**Psychological Testing**

Psychological evaluation and psychological testing can be ordered by a physician but are not covered when performed by an M.D. (These services must be performed and billed by a psychologist who is an enrolled provider.)

## 8400. Updated 04/10

### Psychiatric continued

#### Special Psychiatric Program for Children

This program was developed for children in the KBH program who require intensive therapy above normal Medicaid limitations. Such therapy programs **require PA** and are limited to six months duration.

The process of applications and approval for this special program will follow the guidelines listed below:

- Request PA (refer to Section 4300 of the *General Special Requirements Provider Manual*) to initiate a plan of intensive care.
- Attach to the PA form a complete summary of psychiatric and medical history, prognosis, and treatment goals.
- Progress summaries must be submitted to the Director of Medical Programs, Health Care Policy/Medical Policy, upon request.
- If inpatient psychiatric treatment becomes necessary, the special outpatient treatment program will be suspended. The possible return of the child to the outpatient program after discharge from inpatient services will be re-evaluated by the Adult and Medical Services.

### Radiology

The primary diagnosis code on the claim must reflect the medical need for the procedure.

#### Abdominal Plain Films and Ultrasound

Abdominal plain films and ultrasound are considered medically necessary when the primary diagnosis clearly indicates one of the following:

- Abdominal pain, nausea/vomiting
- Complications associated with ulcers
- Intestinal obstruction
- Gallbladder disease
- Injury to the abdomen or kidneys
- Malignant neoplasm of the abdominal organs

An abdominal plain film may be warranted in a pregnant patient when the patient is in labor, fetal position is questionable, and OB ultrasound is unavailable. Supporting documentation must be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

#### Chest X-Rays

Chest X-rays are considered medically necessary for one of the following:

- History or indication of cardiopulmonary disease, malignancy, cerebrovascular accident (CVA), long bone fracture
- Recent thoracic surgery

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

**8400. Updated 04/10**

**Radiology continued**

- Thoracic injury
- Chronic cough over one month duration

*Note:* Specify as chronic in the diagnosis field. If this specification is not supplied, the condition is considered acute and the X-ray denied.

Preoperative and routine admission chest X-rays are not covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim:

- Sixty years of age or older
- Pre-existing or suspected cardiopulmonary disease
- Smokers over age forty
- Acute medical/surgical conditions such as malignancy or trauma

It may be necessary to contact the ordering physician for medical necessity information.

**CT Scans - Abdominal**

A CT scan of the abdomen is considered medically necessary when the primary diagnosis clearly indicates a malignant neoplasm of the intra-abdominal cavity, lung, genital organs, lymphoma, diseases of the spleen, liver abscess, peritonitis, pancreatitis, abdominal trauma, or abdominal mass.

A CT scan of the abdomen **may** be considered medically necessary for:

- Abdominal Pain - Indicate the severity and length of time the pain, presenting symptoms, suspected conditions, or complications have been present.
- Abdominal Aneurysms - Indicate the presenting symptoms and suspected complications.
- Acute Lymphocytic Leukemia - Indicate the presenting symptoms and a detailed description of area(s) involved.
- Malignant Neoplasm not located in the Intra-Abdominal Cavity, Lung, or Genital Organs - Indicate presenting symptoms and if the CT scan was performed as part of staging the disease process.

Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

**CT Scans - Head or Brain**

A CT scan of the head or brain is considered medically necessary when the primary diagnosis clearly indicates intracranial masses/tumors, intracranial congenital anomalies, hydrocephalus, brain infarcts, parencephalic cyst formation, open or closed head injury, progressive headache with or without trauma, intracranial bleeding, aneurysms, or the presence of a neurological deficit.



## 8400. Updated 04/10

### Radiology continued

A CT scan of the head or brain **may** be considered medically necessary for:

- Headache - Indicate length of time and any accompanying central nervous system (CNS) symptoms.
- Epilepsy - Specify if initial or repeat scan. Indicate if suspected injury occurred during seizure.
- Syncope (fainting) - Specify if recurrent or single episode.
- Dizziness - Specify if recurrent or single episode.
- Acute Lymphocytic Leukemia - Indicate any accompanying CNS symptoms.

Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

### MRI - Head or Brain

An MRI scan of the head or brain is considered medically necessary when the primary diagnosis clearly indicates intracranial injury, intracranial mass/tumor, CNS malignancies, cerebrovascular disorder, cerebral malformations, disorders of the cerebral hemispheres and higher brain functions, demyelinating diseases, extrapyramidal and cerebellar disorders, brain abscesses, encephalitis, tuberculous meningitis, or the presence of a neurological deficit.

An MRI scan of the head or brain **may** be considered medically necessary for:

- Headache - Indicate length of time and accompanying neurologic symptoms.
- Seizure Disorders - Specify if initial or repeat scan and if seizures (or convulsions) are of recent onset, frequency of their occurrence, and any accompanying neurologic symptoms.
- Syncope (fainting) - Specify if recurrent or single episode and any accompanying neurologic symptoms.
- Dizziness - Specify if recurrent or single episode and any accompanying neurologic symptoms.
- Non-CNS Malignancies - Indicate any accompanying neurologic symptoms.

Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

### MRI - Breast

MRI of the breast will be covered with the following indications:

- Staging and therapy planning patients with diagnosed breast cancer
- Occult primary breast cancer when there are no positive axillary nodes and no known primary tumor
- Inconclusive diagnosis after a standard mammography evaluation (for example, when scar tissue from previous surgery, dense breast tissue or breast implants render mammographic images inconclusive)

**MRI used for screening for breast cancer is not justified.**

## 8400. Updated 04/10

### Radiology continued

#### Skull X-Rays

Skull X-rays are considered medically necessary when the primary diagnosis clearly indicates head trauma, primary or metastatic tumors of the skull, or tumors of the pituitary gland.

A skull X-ray **may** be considered medically necessary when indicated for:

- Chronic Sinusitis - Indicate any pertinent specific suspected complications resulting from chronicity.
- Trigeminal Neuralgia - Specify type of lesion suspected.
- Abnormalities relating to the head - Specify if done as an evaluation film for noncosmetic reconstructive surgery. Indicate type of surgery being considered.

Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

#### Sonograms - Nonobstetrical Pelvic

Nonobstetrical pelvic sonograms are considered medically necessary when the primary diagnosis clearly indicates pelvic mass or pain, ovarian cyst, pelvic inflammatory disease, endometriosis, possible retained fetal tissue, or question/history of metastatic disease.

Nonobstetrical pelvic sonograms **may** be considered medically necessary for either:

- Abnormal vaginal bleeding
- Irregular menstrual cycles

It may be necessary to contact the ordering physician for medical necessity information.

#### Upper Gastrointestinal (UGI) Series

An upper gastrointestinal (UGI) series is considered medically necessary when the primary diagnosis clearly indicates persistent dysphagia, melena, symptoms of UGI tract bleeding, or signs and symptoms of ulcers affecting the UGI tract after medication has failed to relieve the symptoms. State guidelines allow one UGI series per day, per beneficiary, regardless of provider.

UGI series **may** be considered medically necessary when nonspecific diagnoses such as abdominal pain or dyspepsia are used. When these common nonspecific diagnosis codes are used, **additional symptoms** and/or circumstances that relate to the medical necessity of the procedure **must be indicated**. For example:

- Is the symptom persistent? If so, how long has the symptom persisted?
- Is the symptom recurrent? When was the last episode?
- Has the symptom or condition increased in severity?
- Was medicinal therapy initiated prior to any procedure being performed? If so, indicate the date each therapy was initiated, name(s) of medication (list all GI related medications tried) and the length of time each medication was tried. What was the patient's response to each treatment?

## 8400. Updated 04/10

### Radiology continued

- If a chronic condition, has there been a change in symptoms? If so, describe the change(s).
- If cancer diagnosis codes are used, what symptoms are present that indicate UGI involvement?

Claims for UGI X-rays are denied reimbursement when the diagnosis code on the claim is either too nonspecific or is the result, rather than the reason, for the procedure. Whenever possible, use the symptoms that most clearly describe the reason for the test.

It may be necessary to contact the ordering physician for medical necessity information.

### Renal Dialysis/Kidney Transplants

When it has been determined a beneficiary has a chronic renal disease (CRD) requiring renal dialysis, the beneficiary or his representative must first apply for Medicare CRD eligibility.

Medicare allows payment of claims for eligible beneficiaries with chronic renal disease and will reimburse for maintenance dialysis the third month after the maintenance dialysis starts. Refer to the Medicare manual for CRD guidelines.

Medicaid will reimburse claims for services related to chronic renal dialysis and/or kidney transplants only after proof has been attached to one claim that the beneficiary has applied for Medicare and coverage has been approved or denied. (The Medicare CRD eligibility information will be retained in the claims processing system. Therefore, subsequent claims do not need to have proof of Medicare application.)

Examples of acceptable proof of application by Medicare are:

- Medicare EOMB/RA
- Beneficiary health insurance card
- Report of confidential Social Security benefit information
- Letter from Medicare or Social Security explaining that the beneficiary has applied for Medicare and whether or not beneficiary is eligible

**8400. Updated 04/10**

**Renal Dialysis/Kidney Transplants continued**

**Hospitals Qualifying for Federal Renal Program**

Univ. of Kansas Med. Center  
39th & Rainbow Boulevard  
Kansas City, Kansas 66103

St. Francis Regional Med. Center  
929 North St. Francis  
Wichita, Kansas 67211

St. Luke's Hospital  
44th and Wornall Road  
Kansas City, Missouri 64111

Research Hospital & Medical Center  
Meyer Boulevard & Prospect  
Kansas City, Missouri 64132

St. Francis Hosp. & Health Center \*  
Topeka, Kansas 66606

1700 West Seventh Street  
The Children's Mercy Hospital  
24th at Gillham Road

Kansas City Dialysis & Training Center \*  
Located at Research Hospital  
Meyer Boulevard & Prospect  
Kansas City, Missouri 64132

Kansas City, Missouri 64108  
(CAPD Training & Support Services)

Asbury Hospital  
400 S. Santa Fe  
Salina, Kansas 67406

**FOR VETERANS:**

Kansas City V.A. Hospital  
4801 Linwood Boulevard  
Kansas City, Missouri 64128

Wichita V.A. Hospital  
5500 East Kellogg  
Wichita, Kansas 67218

**Sterilizations**

**Hysterectomy**

Hysterectomies are covered only for medically indicated reasons. One of the following conditions must also be met and documented. If one of these three options does not apply to the situation for which you have provided service, you may not be reimbursed.

- The individual or her representative signs the Hysterectomy Necessity Form acknowledging receipt of information that the surgery will make her permanently incapable of reproducing. The Sterilization Consent Form is not an acceptable substitute.
- The physician must certify in writing that the individual was already sterile and state the cause or reason for the sterility on an attachment to the claim. The signature in field 31 of the claim form will not suffice.
- For the Sterilization Consent Form only, the physician must certify in writing that the surgery was performed under a life-threatening situation and individual certification was not possible. Include a description of the nature of the emergency. The signature in field 31 of the claim form will not suffice. Refer to Section 4300 of the *General Special Requirements Manual*.

## 8400. Updated 04/10

### **Sterilizations continued**

A copy of the hysterectomy statement **must** be attached to the surgeon's claim at the time of submission. The Hysterectomy Consent Form, located on the public and secure websites, may be photocopied for your use (see the Table of Contents and Introduction pages for hyperlinks). A copy of the hysterectomy statement **is not** required to be attached to related claims (anesthesia, assistant surgeon, hospital, or rural health clinic) at the time of submission. **However, no related claim will be paid until the hysterectomy statement with the surgeon's claim has been reviewed and determined to be correct, unless the related claim has the correct hysterectomy statement attached.**

### **All Sterilizations**

#### **Guidelines**

The following guidelines must be accurately followed before reimbursement can be made for any sterilization procedure (including, but not limited to hysterectomy, tubal ligation sterilization, vasectomy). If each item is not followed completely, it will result in the denial of your claim. KMAP or other authorized agencies may ask for documentation at any time, either during the claims processing period or after payment of a claim, to verify that services have been provided within program guidelines.

- 1) The Sterilization Consent Form mandated by federal regulation, located on the public and secure websites, must be used (see the Table of Contents and Introduction pages for hyperlinks). All voluntary sterilization claims submitted without this specific sterilization consent form will be denied.
- 2) The Sterilization Consent Form must be signed so that 30 days have passed before the date the sterilization is performed with the following exceptions:

#### **Premature Delivery**

- The date of the beneficiary's consent must be at least three calendar days prior to the date the sterilization was performed.
- The expected date of delivery must be indicated on the consent form and the date of the beneficiary's consent must be at least 30 days prior to the expected date of delivery.

#### **Emergency Abdominal Surgery**

- The date of the beneficiary's consent must be at least three calendar days prior to the date the sterilization was performed.
- The circumstances of the emergency abdominal surgery must be described by the physician sufficiently to substantiate the waiver of the 30-day requirement.

The three calendar days time-frame is used in the above exceptions to guarantee compliance with the minimum federal requirement of 72 hours.

**8400. Updated 04/10**

**All Sterilizations continued**

- 3) The Sterilization Consent Form is valid for 180 days from the date it is signed by the beneficiary. Sterilization claims for individuals that reflect dates of service beyond 180 days from the date the consent form was signed will be denied.
- 4) The individual must be at least 21 years of age or older on the date the consent form is signed, or the sterilization claim will be denied. (This includes those situations in which the individual has misrepresented his or her age on the consent form to the provider.) The birth date information provided by SRS will be used to determine whether the individual meets the age requirement. This information can be obtained through Customer Service.
- 5) Sterilizations on mentally incompetent individuals are not covered. "Mentally incompetent individual" is defined as an individual who has been declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilizations (42 CFR 441.251).
- 6) The sterilization is not covered when consent is obtained from anyone in labor, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.
- 7) Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.
- 8) The physician's statement must be signed and dated no more than two days prior to the surgery, the day of the surgery, or any day after sterilization was performed.
- 9) The physician statement on the consent form must be signed by the physician who performed the sterilization. No other signatures will be accepted.

When sterilization results from the treatment of a medical condition, a consent form is not required. However, there must be a note on the face of the claim that states the medical condition that caused the sterility. Claims billed involving these situations will be denied for no sterilization consent form when an explanatory notation is not present on the face of the claim.

The form must be legible in its entirety.

Providers may photocopy this form from the public or secure website (see the Table of Contents and Introduction pages for hyperlinks).

**Note:** Sterilization Consent Form instructions are listed following the form.

**8400. Updated 04/10**

**Transcervical Sterilizations**

Code 58579 is not covered for transcervical sterilization procedures. Code 58565 is to be used. The procedure must meet all sterilization requirements. PA is required.

The Essure Kit is included in code 58565 and should not be billed separately. The invoice does not need to be attached to the claim.

If a beneficiary has had a transcervical hysteroscopy sterilization, a federal sterilization consent form is required. Additionally, three months must have passed before having code 58340 performed. To indicate proof of sterilization, ICD-9 CM diagnosis code V25.2 must be used. PA is not required.

**Surgery**

**Ambulatory/Outpatient Surgery**

Ambulatory surgical centers are allowed reimbursement for the use of operating room, recovery room, and supplies incurred for minor surgical procedures. The ambulatory surgical center must reference the facility number as the performing/rendering provider in field 24J of the CMS-1500 when billing. Charges for ancillary services (such as physician, anesthesiologist, and assistant surgeon) must be billed by those providers involved. Ambulatory surgical centers and outpatient hospitals will be reimbursed for multiple unrelated outpatient surgical procedures performed on the same day as follows: 100 percent of the current Medicaid rate for the highest value procedure; 50 percent of the current Medicaid rate for the second procedure; and 25 percent of the current Medicaid rate for all subsequent procedures.

**Content of Service**

IVs, medications, supplies and injections performed on the same day as an ambulatory outpatient surgery procedure are considered content of service of the surgery and must not be billed separately.

Anesthesia equipment and supplies, drugs, surgical supplies, and other equipment of the operating room and the recovery room are considered content of service of the ambulatory/outpatient surgical procedure.

Exploratory laparotomy and enterolysis of adhesions are considered content of service when performed in conjunction with another major surgery.

Procedures performed in conjunction with an emergency room visit (sutures, minor surgeries, etc.) are considered content of service of the emergency room visit and must not be billed separately. When reimbursement for the procedure is preferred, the *CPT*<sup>®</sup> code for the procedure performed shall be billed in lieu of the ER visit.

**8400. Updated 04/10**

**Surgery continued**

**Surgery - Breast Reconstruction**

Breast reconstruction is covered when one of the breast reconstruction codes is billed with one or more of the covered breast cancer diagnoses, and the beneficiary had a mastectomy for breast cancer on or after March 1, 2005, using one of the mastectomy codes covered. Only the following breast reconstruction codes are covered. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp> or from the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations.

Outpatient Codes		Physician Codes		
11970	11971	11970	11971	19316
19316	19340	19340	19342	19350
19342	19350	19357	19361	19364
19357	19366	19366	19367	19368
		19369	69990	

**Cosmetic Surgery**

All surgeries cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized. (Refer to Section 4300 of the *General Special Requirements Provider Manual*.)

**Diagnostic and Surgical Procedures Performed Outpatient**

Certain diagnostic and surgical procedures are reimbursed at a higher rate when performed in the physician's office, ambulatory surgical center, or outpatient general hospital unit.

**Elective Surgery**

The Medicaid program will not reimburse for elective surgery unless medically necessary for a KBH participant. (Refer to [the KAN Be Healthy Provider Manual](#).)

Certain procedures are reviewed on a postpayment, random sample basis. Retain all documentation supporting the nonelective nature of the surgery in your files for review. Documentation includes admission notes, history and physical, operative report and pathology report.

If documentation does not support the nonelective surgery, reimbursement for **all** claims relating to the surgery will be recovered.

**Major Surgery**

All office visits, hospital visits and nonemergency outpatient visits one day prior to the day of surgery up to a period of 42 days after surgery are content of service of the surgery.



**8400. Updated 04/10**

**Surgery continued**

**Minor Surgery**

All office visits, hospital visits and nonemergency outpatient visits for a period of 21 days after minor surgeries are content of service of the surgery.

Office visits and nonemergency outpatient visits rendered on the same day as surgery are content of service.

*Note:* Medicaid only uses Medicare's global indicators to determine what procedures are considered minor and major procedures for pre/postoperative editing.

**Therapy**

Therapy treatments are not covered for psychiatric diagnosis.

Habilitative – Therapy is covered for any birth defects/developmental delays only when approved and provided by an Early Childhood Intervention (ECI), Head Start, or Local Education Agency (LEA) program. Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. Therapy of this type is covered only for participants age zero to under the age of 21. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children.

Rehabilitative - All therapies **must** be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician.

Therapy services are limited to six months for non-KBH participants (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KBH participants.

Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.

Providers of rehabilitative therapy can submit claims with a combination of the following rehabilitation therapy procedure codes and a diagnosis code in the range of V57.0-V57.9 as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes is billed as a primary diagnosis.

97001	97003	97010	97012	97014	97016	97018
97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124
97140	97150	97530	97535	97750		

**8400. Updated 04/10**

**Therapy continued**

**Occupational Therapy**

Occupational therapy is covered when services are prescribed by a physician and performed by a licensed occupational therapist or a certified occupational therapist assistant working under the supervision of a licensed occupational therapist. When services are performed by a certified occupational therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed occupational therapist initializing each treatment note written by the certified occupational therapy assistant, or the licensed occupational therapist writing "Treatment was supervised" followed by his or her signature.

**Physical Therapy**

Physical therapy is covered when services are prescribed by a physician and performed by a licensed physical therapist or by a certified physical therapy assistant working under the supervision of a licensed physical therapist. When services are performed by a certified physical therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed physical therapist initializing each treatment note written by the certified physical therapy assistant, or the licensed physical therapist writing "Treatment was supervised" followed by his or her signature.

**Speech Therapy**

Speech therapy is covered when services are prescribed by a physician and performed by a certified speech pathologist.

*Note:* Rehabilitative physical, occupational and speech/language therapy services may be provided in the following places of service: outpatient hospitals, rehabilitative hospitals, LEAs (early childhood intervention settings, Head Start and school districts), home health, freestanding clinics, and physicians' offices.

**Providers must consider any place of service editing that pertains to their provider type and specialty and the population served.**

**Transplants**

Liver transplants for Medicaid beneficiaries will only be reimbursed at the University of Kansas Medical Center or at a hospital recommended by their staff.

Heart, lung and heart/lung transplants performed in approved in-state or border city hospitals are covered for **KBH participants only**.

Bone marrow, cornea, kidney, and pancreas transplants performed in approved in-state or border city hospitals are covered and do not require PA. Pancreas transplants are only covered when performed simultaneously with or following a kidney transplant.

## **8400. Updated 04/10**

### **Tuberculosis**

Inpatient services related to a tuberculosis (TB) diagnosis, including physician and laboratory services are covered for beneficiaries with the TB benefit plan.

Inpatient hospitalization, including physicians' services for diagnostic evaluation of beneficiaries highly suspected of TB, is covered for completion of the diagnosis. Acute problems, which are present on admission or arise during hospitalization, are covered services. Hospitalization for monitoring toxicity of anti-tuberculosis drugs is covered.

Inpatient claims may be billed directly to KMAP.

Coverage and payment of inpatient or outpatient services are subject to compliance with infectious disease reporting requirements as directed by K.A.R. 28-1-2.

Coverage and payment of outpatient services are coordinated between KDHE and Kansas Health Policy Authority (KHPA) in accordance with the current interagency agreement. Contact KDHE at 785-296-0739 for determination of coverage.

Anti-tuberculosis drugs to treat the beneficiary and family members are provided at no cost by KDHE. Contact your local health department or KDHE at 785-296-2547.

### **Vagal Nerve Stimulators**

Vagal nerve stimulators (VNS) are covered for beneficiaries with epileptic disorders. With the exception of codes 95970 and 95974, all services must be prior authorized.

VNS services must meet the following conditions:

- The beneficiary must have an epileptic disorder. VNS will not be covered for beneficiaries with previous epileptic brain surgery or beneficiaries with progressive disorders.
- Mental retardation with epilepsy is not a contraindication for VNS but must be considered with other factors.
- All other courses of treatment must be documented, such as conventional and anti-convulsant drugs.
- There is no age restriction. The beneficiary's physicians are expected to determine whether VNS surgery is appropriate and to document those findings in the medical record.
- Providers are expected to maintain adequate documentation, such as "decreased seizure activity" or "improvement in seizure condition."

For the most current information and verification of coverage, access:

- The public website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp> under the Provider tab and Reference Codes
- The secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp> under Pricing and Limitations

**8400. Updated 04/10**

**Vision**

KMAP offers a variety of optical benefits.

- Complete eye examination every four years
- Eyeglasses with certain limitations, see the *Vision Provider Manual*

Many vision services have specific limitations. For further information, the *Vision Provider Manual* may be found on the public website at <https://www.kmap-state-ks.us>.

**Vacuum Assisted Wound Closure Therapy**

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the *Durable Medical Equipment Provider Manual* for criteria. For questions about service coverage for a given benefit plan, contact the KMAP Customer Service Center at 1-800-933-6593 or 785-274-5990. All PA must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

# BENEFITS AND LIMITATIONS

8410. ARNP Updated 10/09

## SERVICES DESCRIBED IN THIS SECTION ARE SPECIFIC TO ARNP PROVIDERS ONLY.

ARNPs may bill for all KMAP services that they are legally allowed to perform. The scope of these services are outlined by the Kansas State Board of Nursing. All services rendered are subject to KMAP limitations that apply to physician services or limitations listed below if the service is not performed by the physician.

ARNPs are reimbursed at 75 percent of the maximum rate set for physicians. Anesthesia services and KBH screens are reimbursed at the same rate as set for physicians.

### Anesthesia

Anesthesia services may be considered for payment when provided by a CRNA enrolled as an ARNP. Anesthesia is the only service reimbursable to CRNAs under KMAP.

### Case Management

Code G9012 is limited to 480 units (15 minutes per unit) per calendar year. Case management must be provided by a pediatric ARNP or general ARNP. PA is required when a beneficiary requires more than 480 units per year of Targeted Case Management. PA requests must be directed to the ACIL program manager at 785 296 3561 (see address following). Services require a HealthConnect Kansas referral; other insurance is primary and must be billed first.

Admission to ACIL services requires program manager approval. Approval for admission into the ACIL program must be obtained in the following manner:

1. Approved ACIL Targeted Case Management (TCM) providers must evaluate beneficiaries for eligibility for ACIL services.
2. If the ACIL TCM provider determines the beneficiary meets eligibility criteria, the ACIL TCM provider must submit the following documentation to the ACIL program manager (see address following):
  - Case Management Provider's Worksheet
  - Assessment Instrument
3. The ACIL program manager will review the submitted documentation and will notify the ACIL TCM provider in writing that the beneficiary has been approved or not approved for admission into the ACIL program.

*Note:* Babies born to mother's assigned to a HealthWave 19 MCO are excluded from ACIL eligibility. The HealthWave 19 MCOs provide the intensive medical care needed for these babies.

**8410. Updated 04/09**

**Case Management continued**

*Note:* Any services not provided in accordance with these processes are subject to recoupment.

ATTN: ACIL Program Manager  
Division of Healthcare Policy  
Docking State Office Building  
915 SW Harrison, 10<sup>th</sup> Floor  
Topeka, Kansas 66612 1570

**Pain Management**

Providers are encouraged to use the Pain Management Guidelines developed by The Federation of State Medical Boards of the United States, Inc. and adopted by the Adult and Medical Services Commission. The guidelines are the following:

**Evaluation of the Patient**

1. A complete medical history and physical examination must be conducted and documented in the medical records.
2. The medical records should document the nature and intensity of the pain, evaluate underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse.
3. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

**Treatment Plan**

1. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned.
2. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

**Informed Consent and Agreement for Treatment**

1. The physician should discuss the risks and benefits of the use of controlled substances with the patient, significant other(s) or guardian.
2. The patient should receive prescriptions from one physician and one pharmacy where possible.
3. If the patient is determined to be at high risk for medication abuse or has a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including:
  - Urine/serum medication levels screening when requested
  - Number and frequency of all prescription refills
  - Reasons for which drug therapy may be discontinued (i.e. violation of agreement)

KANSAS MEDICAL ASSISTANCE PROGRAM  
PROFESSIONAL SERVICES PROVIDER MANUAL  
BENEFITS & LIMITATIONS

**Pain Management continued**

**Periodic Review**

1. At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology of the pain.
2. Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living and quality of social life.
3. If reasonable treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued opioid treatment.
4. The physician should monitor patient compliance in medication usage and related treatment plans.

**Consultation**

1. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives.
2. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion.
3. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

**Medical Records**

1. The physician should keep accurate and complete records to include:
  - a. The medical history and physical examination
  - b. Diagnostic, therapeutic and laboratory results
  - c. Evaluations and consultations
  - d. Treatment objectives
  - e. Discussion of risks and benefits
  - f. Treatments
  - g. Medications (including date, type, dosage, and quantity prescribed)
  - h. Instructions and agreements
  - i. Periodic reviews
2. Records should remain current and be maintained in an accessible manner and readily available for review.

**Pain Management continued**

**Compliance with Controlled Substances Law and Regulations**

1. To prescribe controlled substances, the physician must be licensed in the state of Kansas, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions.
2. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration (and any regulations issued by the State Medical Board) for specific rules governing issuance of controlled substance prescriptions as well as applicable state regulations.

**Definitions**

For the purposes of the pain management guidelines for Kansas Medicaid, the following terms are defined as follows:

**Acute Pain**— Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time limited and is responsive to opioid therapy, among other therapies.

**Addiction**— Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

**Chronic Pain**— A pain state that is persistent and in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

**Physical Dependence**— Physical dependence is a physiologic state of neuroadaptation to an opioid which is characterized by the emergence of a withdrawal syndrome if the opioid use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by readministration of the opioid. Physical dependence appears to be an inevitable result of opioid use. Physical dependence, by itself, does not equate with addiction.

**Substance Abuse**— Substance abuse is the use of any substance(s) for nontherapeutic purposes or use of medication for purposes other than those for which it is prescribed.

**Tolerance**— Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

**Technology Assisted Children's Waiver**

The technology assisted (TA) children's waiver provides special waived services for TA children who would, in the absence of home care services, require a hospital level of care.



**Medical Case Management**

Medical case management is defined as the development of an individualized care plan based on a comprehensive assessment, including financial and complex medical case management. The case manager locates, coordinates, and monitors home care and other services for TA children. Case management must be provided by an ARNP who has experience with the health and social needs of the TA child, fiscal case management, and expertise in the development of assessments, plans of care, monitoring, and utilization review for these children. Case management is limited to 120 hours per calendar year per KBH beneficiary. PA may be requested when a KBH beneficiary requires more than 120 hours of medical case management within the calendar year. PA requests should be directed to the manager of Special Programs at the Health Care Policy Medical Policy, 785-296-3981. Procedure Code T1016 must be indicated when billing for this services.

**Limitations**

- Children must be under the age of 18.
- Children must be ventilator dependent, or require total parental nutrition, or similar conditions.
- Children must be KBH participants.
- Children must be approved as waiver eligible by Medical Services of SRS.
- Services delivered to the child must be contained in a plan of care approved by Adult and Medical Services.

**ARNP SPECIFIC PROCEDURE CODES AND NOMENCLATURE**

KAN Be Healthy participation is required.

**CASE MANAGEMENT**

G9012 (This code to be used for ACIL.) T1016 (This code to be used for TA waiver.)

**KAN BE HEALTHY SCREENS**

Refer to Section 2020 of the *General Benefits Provider Manual*.

# BENEFITS AND LIMITATIONS

## 8420. LOCAL HEALTH **Updated 04/10**

**SERVICES DESCRIBED IN THIS SECTION ARE SPECIFIC TO LOCAL HEALTH DEPARTMENT PROVIDERS ONLY.**

### **Family Planning**

Family planning is any medically approved treatment, counseling, drugs, supplies, or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.

- Code S0610 is limited to one per beneficiary per lifetime. This includes complete physical examination, counseling, and follow-up.
- Code S0612 includes complete physical examination, counseling and follow-up.
- Code S4993 must be billed separately. Billing for contraceptive pills is limited to 13 times per 12 calendar months.
- For interim family planning visits (recheck of contraceptive method, modification of prescription, clinical problems and counseling), use T1001 and E&M codes 99211, 99212, 99213, and 99214 as appropriate.

### **Skilled Nursing Services**

Code T1002 can only be provided by local health departments (LHD) when the services of a home health agency are not available in the county where the beneficiary resides. LHDs must notify the home health program manager in writing (Landon State Office Bldg, 900 Southwest Jackson, Room 900, Topeka, Kansas 66612) that the LHD is providing skilled nursing services in the absence of a home health agency in the beneficiary's county of residence. LHDs must use the current home health procedure code to bill for RN home health skilled nursing services provided to eligible beneficiaries and must bill using their LHD provider number. LHDs will be subject to the same limits and rates as home health agencies for skilled RN services.

### **Prenatal Health Promotion and Risk Reduction**

Prenatal Health Promotion and Risk Reduction (PHP/RR) services are designed to reduce the incidence of poor pregnancy outcomes for the mother and newborn. PHP/RR facilitates the Medicaid beneficiary's access to nursing, nutrition and psycho-social assessments, interventions and referrals based on identified risks, and health promotion education.

PHP/RR services are exempt from a HealthConnect primary care case management (PCCM) referral. If the beneficiary is enrolled in a Medicaid HMO, the local agency will need to contract directly with the HMO to seek reimbursement from the HMO.

## **8420. Updated 04/10**

### **Billing Codes**

PHP/RR may be billed under H1000 for a single visit (with a maximum of three visits) or under code H1005, for a total package of three visits.

### **Service Periodicity**

Services ideally occur once a trimester, with the initial assessment ideally taking place during the first trimester and follow-up visits occurring during the second and third trimester. Services, however, may be provided anytime during the pregnancy depending on when contact with the beneficiary is initiated.

### **Service Components**

1. Data Base Collection and Risk Identification
2. Confirmation of participation in or referral to prenatal medical care
3. Notification of prenatal medical care provider of beneficiary participation in service and risks identified
4. Referral to appropriate support services
5. Follow-up face-to-face contact based on the beneficiary's risks/needs, to include health promotion education

### **Assessment Components**

1. Obstetrical care provider name & compliance with care
2. Demographic data, e.g. marital status, age, race, emergency contact, other insurance
3. Medical history (family and self)
4. Past obstetrical history
5. Current obstetrical history and pregnancy status
6. Prepregnancy weight status and weight gain/loss
7. Psychosocial/environmental, e.g. attitude toward pregnancy, support systems, living arrangements, employment, emotional/stress factors
8. Nutrition Screen
  - a. Frequency of meals/snacks, eating pattern, quantity and quality of food selections
  - b. Unusual dietary practices, e.g. faddism, food avoidance, elective nutrient and/or vitamin supplementation
  - c. Nutrition knowledge, e.g. expectation about weight gain/loss, management of morning sickness, constipation, heartburn
  - d. Behavioral risk factors, e.g. alcohol and/or other substance use

### **Health Promotion Education**

Education should be based on risks/needs. Coordination with the prenatal medical care provider and other members of the health care team is recommended. Education is to be provided during face-to-face contacts, with documentation by topic presented.

## 8420. Updated 04/10

### **Health Promotion Education continued**

Topics for health education should include: prenatal care regimen; normal pregnancy, labor/delivery and postpartum course; maternal physiologic, social and emotional changes; risks for, prevention and identification of preterm labor and other changes of pregnancy status; nutritional needs of pregnancy/lactation; behavioral risks such as substance use, smoking, alcohol consumption; need for dental assessment/care; fetal growth and development; preparation for labor/delivery; importance of and preparation for breastfeeding; parenting and infant care skills; and family planning.

### **Referrals**

Referrals should be made to WIC, Healthy Start, public health prenatal services and other health department services and/or other support services based on the beneficiary's needs/risks. Documentation of referrals should be made in the case record.

### **Provider of PHP/RR**

RN or primary obstetrical care provider on agency staff or on contract with local agency.

*Note:* For additional guidance regarding nursing assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

### **Prenatal Health Promotion Risk Reduction - High Risk Nutrition Services**

Prenatal Health Promotion Risk Reduction High Risk Nutrition (PHP/RRHRN) services facilitate access to nutrition assessments and interventions by a registered/licensed dietitian (RD/LD) based on the initial nutritional screen done by an RN or primary obstetrical care provider.

PHP/RRHRN services are exempt from a HealthConnect primary care case management (PCCM) referral. If the beneficiary is enrolled in a Medicaid HMO, the local agency will need to contract directly with the HMO to seek reimbursement from the HMO.

### **Billing Codes**

Code S9470 may be billed **before** H1000 or H1005 are billed. Code S9470 must be billed on a separate claim form from other services since only the federal portion (FFP) is reimbursed by Medicaid. Reimbursement for these services may only be made to approved local agencies.

### **Service Periodicity**

The frequency and spacing of visits must be determined by RD/LD based on the nutritional necessity indicators and may include both prenatal visits and one postpartum visit.

## 8420. Updated 04/10

### Indications

The initial nutritional screen done by the nurse or primary obstetrical care provider shall support nutritional necessity for referral to an RD/LD for high risk nutrition services to be reimbursed.

Indicators of nutritional necessity include current diagnosis of any of the following conditions that jeopardize nutritional status: inappropriate weight gain/loss; existing diabetes or gestational diabetes; anorexia nervosa or bulimia; GI tract disease or conditions (e.g. celiac disease, regional ileitis, ulcers/ulcerative colitis); genetic disorders (e.g. cystic fibrosis, galactosemia, hyperlipidemia, PKU); HIV/AIDS; vitamin or mineral deficiencies.

### Service Components

1. Nutrition Assessment Update, e.g. reassessment of anthropometric, dietary, and hematologic data
2. Development of nutritional care plan based on updated assessment
3. Provision of one-on-one nutritional counseling, in collaboration with the primary obstetrical care provider

### Providers of High Risk Nutrition Services

RD/LD on agency staff or on contract with approved local agency.

*Note:* For additional guidance regarding nutrition assessments and interventions, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

### Prenatal Health Promotion/Risk Reduction Enhanced Social Work Services

Prenatal Health Promotion/Risk Reduction Social Work Services (PHP/RRESW) are to provide access to professional social work services by licensed social workers for pregnant and postpartum women who are identified by an RN, licensed social worker and/or primary obstetrical care provider that support a psychosocial necessity.

PHP/RRESW services are exempt from a HealthConnect primary care case management (PCCM) referral. If the beneficiary is enrolled in a Medicaid HMO, the local agency will need to contract directly with the HMO to seek reimbursement from the HMO.

### Billing Codes

Code H1002 must be billed on a separate claim form from other services since only the federal portion (FFP) is reimbursed by Medicaid. Reimbursement for these services may only be made to approved local agencies. Services may be billed by increments, e.g. .25 equals 15 minutes, .50 equals 30 minutes, .75 equals 45 minutes.

## 8420. Updated 04/10

### Service Periodicity

Frequency and spacing of visits must be determined by a licensed social worker based on psychosocial necessity indicators. Maximum of 10 hours per calendar year, which may include prenatal and postpartum contacts.

### Indications

The initial psychosocial screen must support a necessity for referral for enhanced social worker services to be reimbursed.

Indicators of psychosocial necessity include: situations that compromise the beneficiary's ability to enter, continue, and/or comply with prenatal care or make behavioral changes that would impact the pregnancy outcome; limited or lack of support systems; assessed to be at risk for abuse for or are in an abusive environment; and/or have concerns about the effect of the pregnancy on their life goals and pregnancy outcome.

### Service Components

1. Psychosocial Needs/Risk Assessment Update, e.g. review of initial screen and completion of a professional social work intake
2. Development of social work care plan based on current assessment, e.g. prioritizing needs, setting clients goals, plans for follow-up
3. Provision of one-on-one counseling in collaboration with the primary obstetrical care provider and other team members

### Provider of Enhanced Social Work Services

Licensed social workers (LASW, LBSW, LMSW, LCSW) on staff or on contract (appropriate to level of licensure) with approved local agencies.

*Note:* For additional guidance regarding social work assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

### Postpartum/Newborn Home Visit

The Postpartum/Newborn Home Visit (PP/NBHV) provides a transition between the in-patient obstetrical newborn services and the mother's and infant's entry into postdelivery out-patient care.

PP/NBHV services are exempt from a HealthConnect primary care case management (PCCM) referral. If the beneficiary is enrolled in a Medicaid HMO, the local agency will need to contract directly with the HMO to seek reimbursement from the HMO.

### Service Periodicity

One home visit/mother-baby unit, provided by an RN, is made within 28 days after the neonate's date of birth. No risk indicators are required to provide this home visit.

## 8420. Updated 04/10

### Billing Code

Code 99502 can be billed using either the mother's or newborn's current Medicaid number. If using the mother's Medicaid number, the claim form should also include the newborn's date of birth. ~~first and last name or~~ If the newborn's first name has not been determined, state "Baby Boy", "Baby Girl", or "Newborn" in the first name field and ~~enter then~~ the newborn's last name.

### Assessment Components

- Maternal – such as postpartum physiological, emotional status, and nutritional status; interaction with and care skills for newborn; family planning; follow-up medical care appointment(s); employment/education plans
- Newborn – such as physiological and nutritional status; weight assessment as indicated; appointment(s) for health care follow-up
- Parenting and home – such as parenting knowledge/skills; awareness of schedule for newborn/child health assessments/immunizations; home environment
- Support systems – source for primary health care; other support

### Service Components

- Parenting and Health Promotion Education based on individual needs/risks
- Provision of information on well-child assessments and immunizations
- Provision of information on, at a minimum, SIDS prevention, car seat use, and shaken baby syndrome
- Referral based on individual needs/risks

### Provider

RN on staff or on contract with local agency.

*Note:* For additional guidance regarding postpartum and newborn nursing assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal* and *Volume II, Children and Youth*, Kansas Department of Health and Environment.

## Dental Services

Local health departments enrolled with Medicaid may bill for dental services provided to Medicaid beneficiaries and must obtain a separate dental provider number to provide dental services through KMAP. Dental services are billed on the American Dental Association (ADA) form. Please contact Customer Service at 1-800-933-6593 for all dental-related questions. Providers may also refer to the *Dental Provider Manual* on the website at <https://www.kmap-state-ks.us/Public/providermanuals.asp>.

# BENEFITS & LIMITATIONS

## 8430. KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT (KDHE) STATE LABORATORY Updated 04/10

### Covered Services

KDHE laboratory services are covered for Medicaid beneficiaries. The following laboratory services are covered:

- Neonatal Chemistry
- Virology/Serology
- Inorganic Chemistry
- Diagnostic Microbiology

Laboratory services billed by the KDHE lab shall be reimbursed at federal financial participation (FFP) only.



## CODES

The Kansas Health Policy Authority (KHPA) requires KHPA Medical Plans professional billers to submit claims using the Health Care Financing Administration Common Procedure Code System (HCPCS). HCPCS is a combination of codes which includes *CPT*<sup>®</sup> (Current Procedural Terminology) codes created and controlled by the American Medical Association (AMA); Centers for Medicare & Medicaid Services (CMS) codes created and controlled by CMS; and local codes created and controlled by the regional CMS office. HCPCS codes consist of a five-digit base code with the capability of being up to thirteen digits in length when modifiers are used. A modifier code is a two-digit code that identifies a specific type of service, for example, anesthesia, or a variation of the service identified by the base code. A chart has been developed to assist providers in understanding how KHPA will handle specific modifiers. The Coding Modifiers chart is available on both the [public](#) and [secure](#) websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information on the American Medical Association is available at <http://www.ama-assn.org>.

Not all codes are covered. 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 is available at: <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>.
- Information from the secure website is available under Pricing and Limitations after logging on at: <https://www.kmap-state-ks.us/provider/security/logon.asp>.

For further assistance, contact the Customer Service Center at 1-800-933-6593. (Refer to Section 1000 from the *General Introduction Provider Manual*.)

All claims must be coded with the appropriate codes. Claims which only describe the service and do not provide the code will be denied. When a code is not available, the service is noncovered by KHPA Medical Plans. Not otherwise classified (NOC) codes are noncovered. (Refer to Section 4200 of the *General Special Requirements Provider Manual*.)