Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

General Benefits

Updated 06.2023

PART I
GENERAL BENEFITS FEE-FOR-SERVICE
KANSAS MEDICAL ASSISTANCE PROGRAM

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

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

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General Benefits

INTRODUCTION Updated 12/17

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to the Kansas Medical Assistance Program (KMAP) upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees 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.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality 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.

2000. FEE-FOR-SERVICE MEDICAID PROGRAM AND KANCARE Updated 06/21

Introduction to Eligibility

Eligibility in Kansas is based on uniform statewide criteria. Eligibility determinations are made primarily at the KanCare Clearinghouse using the Kansas Eligibility Enforcement System (KEES). KEES then sends an eligibility file to the fiscal agent. Each claim submitted by providers for payment processing is verified for member eligibility. Unless an individual is identified as eligible for the date of service submitted, payment cannot be made for a Medicaid or MediKan claim.

Plastic Medical Card

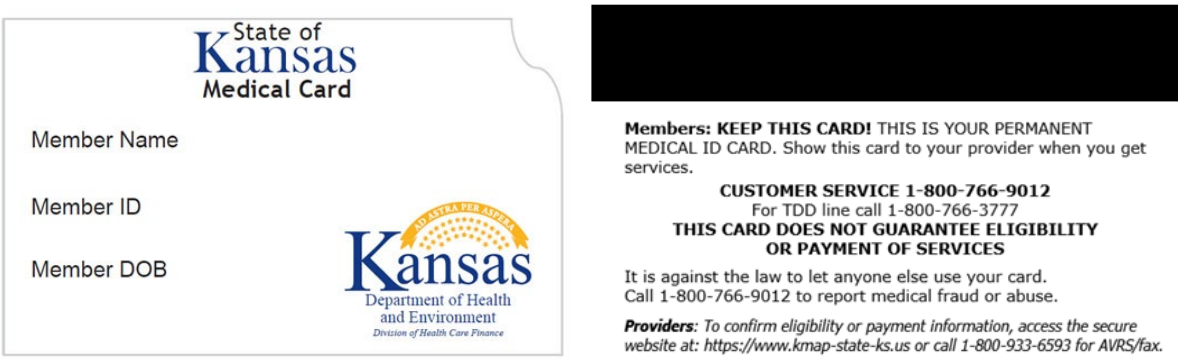
Most members not assigned to a KanCare plan will receive a plastic State of Kansas Medical Card. The plastic medical card contains three key pieces of information: member name, member ID, and member date of birth. The plastic medical card will only be reissued if there is a change in member name or member ID. If the member becomes eligible after more than 12 months of ineligibility, a new plastic medical card will be issued. Cards can be replaced if requested by the member in certain situations. If a member is assigned to a KanCare health plan, they will only get an ID card from the assigned plan.

Eligibility information does not appear on the plastic medical card. Providers are responsible for verifying eligibility and coverage before providing services. Possession of a card does not guarantee eligibility. Changes in eligibility, assignment, spenddown amounts, level of care, copayment amount, and other coverage indicators may occur. Verification at the time of each service is extremely important. It is possible for a member to present a card during a period of ineligibility. A provider may check eligibility using the following methods:

- **Magnetic Swipe Technology**
  - The plastic medical card uses the same swipe technology used for credit cards.
  - This technology allows providers to use a card reader and a service provider to automatically access real-time member eligibility information through MMIS.
- **AVRS (Automated Voice Response System)**
  - This resource automatically provides the member's eligibility over the telephone.
  - It is available 24 hours a day, seven days a week.
  - The entire call takes less than one minute.
- **AVRS Faxback**
  - This resource sends a fax to the provider's fax machine with the member's eligibility listed.
  - The fax service is available 24 hours a day, seven days a week.
- **Secure KMAP Website**
  - The secure KMAP website allows staff with authorization to conduct real-time eligibility verifications.
  - Staff simply enters the member's ID and the date of service.
  - This service is available 24 hours a day, seven days a week.
- **Customer Service**
  - Eligibility can be verified by calling KMAP Customer Service at 1-800-933-6593 and speaking with an agent.
  - This service is available between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday.

2000. Updated 06/21

Plastic Medical Card continued
Below is an example of the plastic State of Kansas Medical Card, and an explanation of the information included on the front and back.



- The front of the card contains the member name, member ID, and member date of birth (DOB).
- The back of the card contains a magnetic stripe, as well as important information for both the member and the provider.

Filing Proof of Eligibility
When a claim is denied "member ineligible for date(s) of service" on the remittance advice (RA) and the provider had proof of KMAP eligibility, the provider should call Customer Service regarding the denial. If the provider did not have proof of insurance but has it now, the provider should resubmit the claim. Any of the following documentation is acceptable for proof of KMAP eligibility:

- A verification number from the Member Eligibility Verification System (BEVS) accessed from the AVRS or point of sale (POS) inquiry
- A printout from POS BEVS

When the only proof of Medicaid eligibility is the verification number received from AVRS, indicate this number on the claim or attachment(s) and submit for special handling to:

Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

Assistance Obtaining Medicaid ID Number
Request member eligibility information through AVRS, using the eligibility instructions outlined in **Section 1210** of the *General Introduction Fee-for-Service Provider Manual*, or POS BEVS, using the eligibility instructions provided in the accompanying manual.

Copayment
Federal guidelines allow states to require a copayment (a share of the cost of certain services) for which the KMAP member must pay.

Federal law mandates that a provider cannot deny services to a member because he or she is unable to pay the current or prior copayment. Providers may ask whether the member is able to pay the copayment amount at the time of service.

Copayment continued
If the member states an inability to pay the copayment, providers must accept this statement and may not collect the copayment from the member at that time. Inability to pay copayment at the time of service does not remove the member's responsibility to make payment at a future time. Providers may offer payment plans to members, if necessary.

Copayment Exemptions
The list below is not all inclusive. Refer to Section 8100 of the specific provider manual for copayment requirements applicable to the services provided.

Members
- Residents in adult care homes, swing bed nursing facilities or Home and Community Based Services (HCBS)
- Members under 18 years of age
- Members 18 to 21 years of age, or 65 years of age or older, who are inpatients in a state psychiatric facility
- Members enrolled in a managed care organization (MCO)
- Members eligible for Medicaid due to a diagnosis of breast or cervical cancer
- Members in out of home placement and in Kansas Department for Children and Families (DCF) or Kansas Department of Corrections (KDOC) custody at least 18 but under 21 years of age
- American Indian or Alaskan Native, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services

General Services
- Alcohol and drug addiction treatment
- Family planning
- Services related to pregnancy
- Attendant Care for Independent Living (ACIL)
- Indian Health
- Maternity center
- Emergency services (as defined by the diagnosis)
- Noncovered KMAP services
- Medical services related to an injury incurred on the job during a community work experience project
- Emergency medical services for aliens

Spenddown
In some cases, the income of a family or individual exceeds the income standard to receive public assistance monies. However, their income is not sufficient to meet all medical expenses. The family group/individual must then incur a specified amount of medical expenses before they are eligible for Medicaid benefits. This process is referred to as **spenddown**.

Identifying Spenddown Members
Refer to **Section 2000** for eligibility information.

Spenddown continued

Claims Processed Against the Spenddown Amount

The spenddown amount will be reduced by expenses for medically necessary services of eligible members but not allowed for in the state Medicaid plan in one of two ways.

Providers enrolled with KanCare and Medicaid should bill KanCare MCO/Medicaid FFS for these services. The system will deduct appropriately billed amounts from the appropriate spenddown, or the member can mail medical bills from non-Medicaid providers to the KanCare Clearinghouse. Proof of TPL resolution must be included. These bills will be manually entered into MMIS as member-billed claims and applied to the appropriate spenddown.

The spenddown amount will be handled like a "deductible." The system will automatically credit the spenddown amount when KanCare/Medicaid providers bill claims for medically necessary services. Billed charges apply to spenddown in date-processed order. Providers should bill all services regardless of whether they believe they are KanCare/Medicaid-covered services so that all charges can appropriately apply toward spenddown.

Providers will be reimbursed for claims submitted for QMB-covered services rendered to QMB/Medically Needy dual eligible. These services are not affected by unmet spenddown.

Member Responsibility

Each time a provider-billed or member-billed claim is used to reduce the spenddown, the system will identify the need for a notice to be sent to the member explaining which service(s) were used to credit the spenddown and what the new remaining spenddown amount is. These notices will be mailed to members weekly. The member is responsible for the payment of all bills used to reduce their spenddown amount.

Providers Reimbursement Maximized

Each claim used to reduce a member's spenddown amount will be flagged to identify whether the claim would have paid if spenddown had been met. In the event a claim is submitted which exceeds the amount of spenddown remaining, all claims for the member will be reviewed.

Claims that are for noncovered services or for services that would not otherwise have been paid by KanCare/Medicaid will be applied to spenddown first. Processed claims that would have paid if spenddown were met will be applied to spenddown in reverse date order. Once the spenddown amount is met, the fiscal agent or KanCare health plan will adjust any remaining payable claims so that the provider may receive reimbursement for the services rendered.

Transportation Services

Depending on a member's benefit plan, commercial nonemergency medical transportation (NEMT) services may be covered or noncovered. If a member is assigned to a KanCare health plan, commercial NEMT services are the responsibility of the member's KanCare health plan.

If a member is assigned to a KanCare health plan, he or she should be instructed to contact his or her assigned KanCare health plan to obtain commercial NEMT services.

2000. Updated 06/21

Transportation Services continued
Trips excluded:

- Trips to WIC clinics
- Trips to LEAs
- Trips to educational classes or day care services
- Errands or shopping
- Trips to attend nutrition, diabetic or other informational classes
- Trips for noncovered services like breast enhancement or weight management

Meals and lodging related to out-of-state or overnight travel may be reimbursed when deemed medically necessary by the member's health care professional or approved by the State's PA unit.

- For KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-PSDT) children 20 years of age and younger, payment for lodging and meals for the member and one parent or guardian may be allowed daily. If the member is receiving inpatient services, meals for one parent or guardian will be reimbursed. In lieu of meals out, groceries may be reimbursed.
- For members who are not KBH-EPSDT, payment for an attendant's meals and lodging may be allowed daily. If the member is receiving inpatient services, meals for one attendant will be reimbursed. In lieu of meals out, groceries may be reimbursed.
- The member may be instructed to contact and use facilities such as Ronald McDonald House and Via Christi Guest Lodging before other lodging is considered.

Sterilizations
The KanCare health plans are responsible for payment of sterilizations. The KanCare health plan must ensure that a completed Sterilization Consent Form is available upon request.

Third-Party Insurance
The KanCare health plans are responsible for collecting and reporting TPL from the third-party insurance if services are provided by the Medicaid contracting MCO.

Ordering, Referring, Attending, Prescribing, and Sponsoring Provider Requirements
Federal regulations (42 CFR 455.410) require ordering, referring, attending, prescribing, and sponsoring (ORAPS) physicians (or other professionals providing services under the state plan or under a waiver of the plan) to be enrolled as participating providers with the state Medicaid agency.

Federal regulation 42 CFR 455.440 requires all Medicaid claims for payment of items and services that were ordered, prescribed, or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, prescribed, or referred the item or service. All physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid members (or other professionals who provide services under the state plan) are required to enroll with KMAP.

2010. MEDIKAN Updated 12/22

Introduction to the MediKan Program

The State of Kansas has a reduced set of benefits which covers members receiving General Assistance. These members are only eligible for services provided under the assistance program entitled MediKan. The MediKan program is designed to provide medical care in acute situations and during catastrophic illnesses for adults 18 years of age and older. There are no children (17 years of age or younger) in the MediKan program except for emancipated minors.

MediKan Benefits and Limitations

Medicaid and MediKan benefits and limitations are addressed separately in Part II of the program specific provider manual. **Please refer to Section 8300 of the specific provider manual for detailed information regarding MediKan benefits and limitations**. Although all basic Medicaid policies also apply to MediKan members, it is important that **Section 8300** is referenced to contrast the specific differences in coverage between Medicaid and MediKan.

Identifying MediKan Members

See **Section 2000** for complete information on eligibility verification.

Noncovered MediKan Program Areas

- Adult day treatment
- Behavior management
- Chiropractic
- Dental
- HCBS
- Intermediate/day treatment alcohol and drug addiction treatment facility services
- Podiatry
- Procedure codes for drugs and biologics deemed a Physician Administered Drug (PAD)
- Vision services

Many other services are offered on a limited basis. (For example: DME - Wheelchairs are **NOT** covered for rental or purchase.) Check the specific provider manual for MediKan coverage information.

Prescription Drug Coverage

Retail pharmacy benefits for MediKan members are limited to drugs that have been accepted for inclusion on the MediKan-specific formulary.

2030. QUALIFIED MEDICARE BENEFICIARIES Updated 06/21

Introduction to QMB

In accordance with the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, Medicare has expanded coverage to include catastrophic health care to those members who are entitled to Medicare Part A benefits and who meet federal income criteria. Currently, the State of Kansas pays the Medicare premium, deductible, and coinsurance for Qualified Medicare Beneficiary (QMB) individuals with some restrictions (see limitations listed below). These individuals fall into two categories, either those eligible for both QMB and Medicaid benefits or those eligible **only** for QMB benefits.

Identifying QMB Beneficiaries

See **Section 2000** for complete information on eligibility verification.

QMB Benefits and Limitations

The QMB program enables payment of Medicare premiums, deductibles, and coinsurance (with some restrictions) for eligible members.

Member eligibility benefits fall into two categories:

1. QMB Only
    - Medicare covered services only. Medicaid considers paying the Medicare copayment, coinsurance, and deductible, but **the total payment the provider receives will never be more than the Medicaid allowed amount.**
    - QMBs are not eligible for payment of claims for Medicaid services which Medicare does not cover.
2. Medicare (QMB) + Medicaid (Dual Eligible)
    - Medicare covered services. KanCare/Medicaid considers paying the Medicare coinsurance and deductible, but **the total payment the provider receives will never be more than the KanCare/Medicaid allowed amount.**
    - KanCare/Medicaid services. Dual eligibles are eligible for payment of KanCare/Medicaid services not covered by Medicare. Claims are subject to the normal KanCare/Medicaid limitations described below.

In either case of QMB coverage, if Medicare covered a service, KMAP limitations do not apply and are bypassed.

Medicaid Program Limitations

- Prior authorization (PA) requirements
- KBH requirements
- Medical assessment review

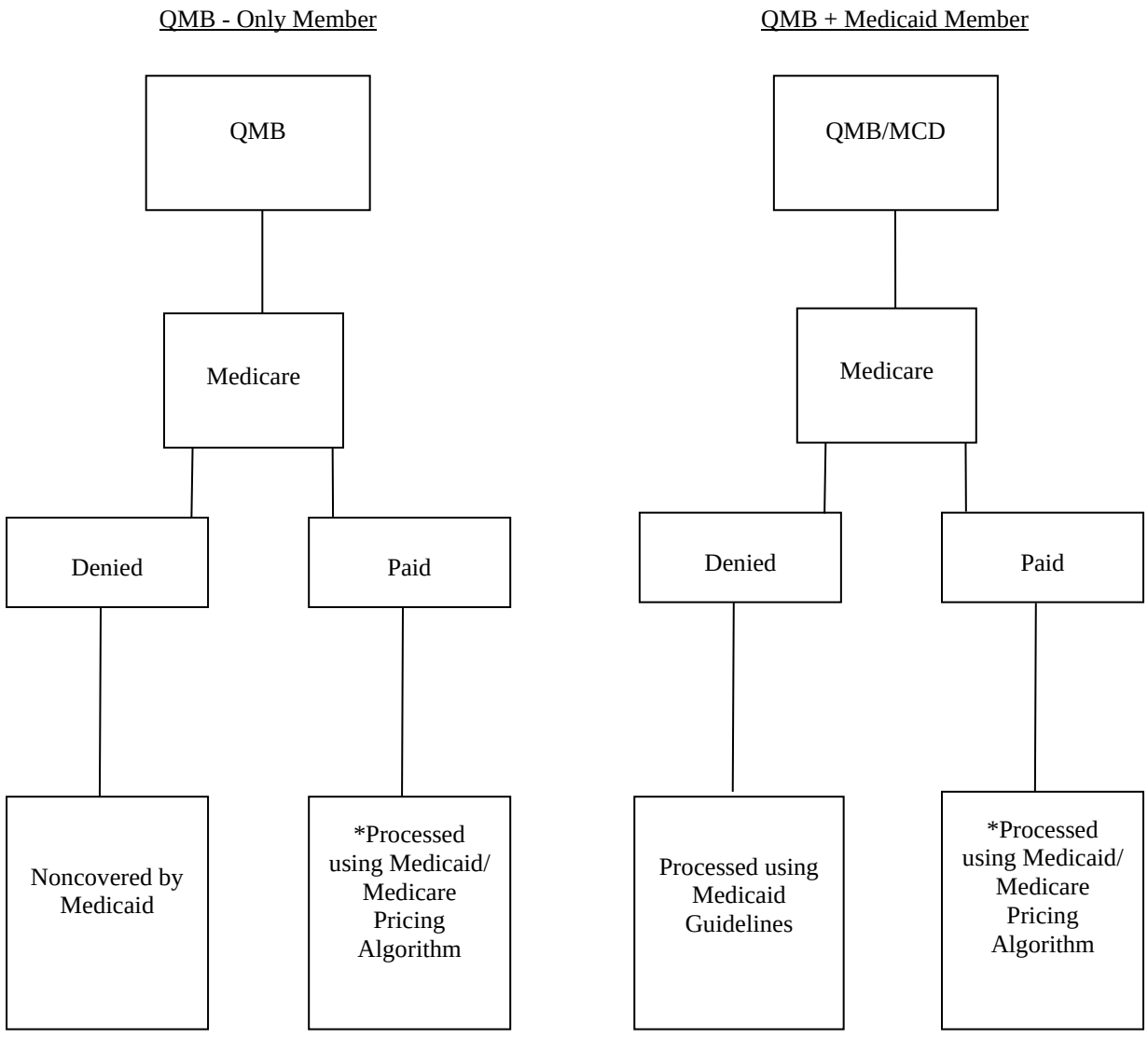
Some services Medicare covers are not KanCare/Medicaid-covered services. The QMB program requires the fee-for-service Medicaid program to consider the coinsurance and deductible on a claim, even if Medicaid does not cover the service. The fee-for-service Medicaid program will never pay for non-Medicaid covered services received by anyone not in the QMB program.

For information on state copayment requirements as they apply to QMB, refer to **Section 2000**.

2030. Updated 06/21

Billing QMB Claims
File claims for QMB services in accordance with standard Medicaid billing practices. (Guidelines regarding Medicare assignment remain the same). All required claim information must be present, valid, and correct or the claim will deny.

The following charts are a representation of the two methods of processing claims for QMB members. The chart to the left represents coverage/processing methodology for a QMB-only member. The chart to the right represents the process for a member qualified for both QMB and Medicaid benefits.



*Applies to all Medicare-covered procedures, including those noncovered by Medicaid.

*Applies to all Medicare-covered procedures, including those noncovered by Medicaid.

2030. Updated 06/21

Low Income Medicare Beneficiaries Program

Medicaid also administers the Low-Income Medicare Beneficiaries (LMB) program as part of the above federal authorization and the Balanced Budget Act of 1997. Under these provisions, members are eligible for full or partial payment of Medicare premiums according to their income level. Participation in the program is transparent to providers, and there are no Medicaid benefits beyond premium payment.

2040. EMERGENCY MEDICAL SERVICES FOR ALIENS: SOBRA Updated 06/23

Introduction to SOBRA - Emergency Medical Services for Aliens
Medical review of emergency services for establishing Sixth Omnibus Budget Reconciliation Act (SOBRA) eligibility are coordinated through the fiscal agent office. Providers seeking coverage of emergency services for SOBRA members must contact the KanCare Clearinghouse at 1-800-792-4884. The member will be required to complete an application for KanCare.

Once financial eligibility for Medicaid has been determined, the KanCare Clearinghouse will initiate a Medical Review of Emergency Services for Purposes of Establishing SOBRA Eligibility (MS-2156) form and forward the form to the provider, with a request that the provider complete Section II of the form. The provider will need to attach the form to medical records that document the emergent nature of the service(s) being billed for the member and return the form and records to the KanCare Clearinghouse. This information must be timely returned to the eligibility worker within 12 days of receipt of form.

The form and medical records must be mailed or faxed to:

KanCare Clearinghouse
PO Box 3599
Topeka, KS 66601
Fax: 1-800-498-1255

2300. BORDER CITY/OUT-OF-STATE PROVIDERS Updated 01/18

When a provider is in a state other than Kansas, and services are rendered in that state, the provider must be licensed and otherwise certified by the proper agencies in his or her state of residence as qualified to render the services for which the charge is made. Certain cities, within 50 miles of the Kansas border, may be closer for Kansas residents than major cities in Kansas, and therefore these cities are considered Border Cities (see list below). This list is not all-inclusive. Others are considered out-of-state and require PA.
(Refer to **Section 4300** of the *General Special Requirements Fee-for-Service Provider Manual*).

ARKANSAS
Bentonville
Gateway
Gravette
Rogers

COLORADO
Arapahoe
Burlington
Campo
Cheyenne Wells
Eads
Eckley
Idalic
Joes
Kirk
Lamar
Lycan
Springfield
Stonington
Stratton
Vilas
Vona
Walsh
Wiley
Wray
Yuma

MISSOURI
Anderson
Appleton City
Asbury
Belton
Blue Springs
Burlington Junction
Butler
Carthage
Claycomo
Craig
El Dorado Springs

MISSOURI (cont.)
Excelsior Springs
Gladstone
Golden
Gower
Grandview
Harrisonville
Independence
Jasper
Joplin
Kansas City Metro
King City
Lamar
Lee's Summit
Liberty
Maryville
Monett
Mound City
Mt. Vernon
Nevada
Noel
North Kansas City
Oregon
Parkville
Platte City
Plattewoods
Pleasanton
Raytown
Rich Hill
Rockport
St. Joseph
Sarcoxie
Savannah
Seligman
Seneca
Sheldon
Smithville
Stanberry
Tarkio
Urich

MISSOURI (cont.)
Warrensburg
Webb City

NEBRASKA
Alma
Araphoe
Auburn
Axtell
Ayr
Beatrice
Beaver City
Benkelman
Bertrand
Blue Hill
Cambridge
Chester
Clay Center
Cortland
Curtis
Deshler
Elwood
Fairbury
Falls City
Franklin
Geneva
Hastings
Hayes Center
Hebron
Holdrege
Humboldt
Indianola
Kearney
Maywood
McCook
Minden
Nelson
Oxford
Pawnee City
Red Cloud

NEBRASKA (cont.)
Sterling
Stockville
Superior
Sutton
Table Rock
Tecumseh
Wilsonville
Wymore

OKLAHOMA
Afton
Alva
Bartlesville
Beaver
Blackwell
Boise City
Buffalo
Cherokee
Cleveland
Collinsville
Commerce
Dewey
Enid
Grainola
Grove
Guymon
Hooker
Laverne
Medford
Miami
Nowata
Pawnee
Ponca City
Vinita
Wakita
Waynoka
Woodward

2400. PROGRAM INTEGRITY Updated 06/21

Historically, to monitor quality of care, Medicaid used retrospective utilization review which looked at documentation of treatment related to specific episodes of care. Because Medicaid has altered the ways in which it purchases health care it has become necessary to reevaluate the quality management program. The primary catalyst for change has been the shift to managed care, and specifically, the inclusion of MCOs as service providers. Since reimbursement is through a capitation method under managed care, Medicaid must evaluate the overall health outcomes of the Medicaid population rather than looking only at treatment associated with specific episodes of care. The following components comprise the Medicaid outcome-based quality management program and are being implemented according to the principles of continuous quality improvement.

Goals of the Medicaid quality management program are to:

- Improve the quality of health care provided to members through a process of continuous quality improvement
- Improve member access to medically necessary services
- Encourage appropriate utilization of services and benefits

There are many processes and procedures utilized within the Medicaid quality management program which exist to protect the integrity of the program and the quality of services provided to the member. Examples of these include the following:

System Edits and Audits
The claims processing system consists of edits and audits which automatically check each claim for accuracy and validity. In addition, claims are processed through rebundling software which identifies inappropriately unbundled codes and rebundles them to a code which is inclusive of the codes originally billed separately.

Utilization Review
Services reimbursed by Medicaid are subject to a manual review process in which medical professionals review documentation in the provider's records to ensure services were performed as billed and in quantity and form which reflects quality and generally accepted standards of care.

KMAP Audit Protocols
The KMAP Audit Protocols are available on the Provider page of the KMAP website under the *Helpful Information* heading.

Standards of Care
Standards of care utilized by Medicaid include nationally recognized standards such as those recommended by the American Academy of Pediatrics regarding well-child visits which pertain to the Medicaid KBH program.

Medicaid also recommends initial prenatal visits occur as follows:

- First trimester, visit within 14 days of first request
- Second trimester, visit within seven days of first request
- Third trimester, visit within three days of first request
- High risk pregnancies, visit within three days of identification of high risk

PROGRAM INTEGRITY continued

Other standards utilized by Medicaid in KMAP:

- Members must have 24-hour access, seven days a week to medical advice.
- In-office appointment wait times must not exceed two hours from the time of the scheduled appointment.
- Urgent care appointments are provided within two days of when the member presents or calls with symptoms of sudden or severe onset.
- Routine preventive care appointments (non-KBH) are made available within 45 days of the member's request.
- 85% of a provider's KBH population is up to date on KBH screens for those members who have been with the provider for one or more years.
- Remedies/corrective action plans are responded to by the provider within the time frames requested.

There are many standards against which Medicaid must measure clinical/nonclinical services. The above list is not considered exhaustive and is to be used as an example.

Provider Satisfaction Surveys

Written surveys occur on a yearly basis and are sent to all providers in the fee-for-service Kansas programs. The intent of these surveys is to obtain feedback from providers in regard to program implementation and suggestions for improvement in program policies or processes.

Member Satisfaction Surveys

Yearly surveys are completed to determine the level of member satisfaction with the program in regard to access, quality of care, and barriers to obtaining services.

Monitoring of Clinical/Nonclinical Data

This includes ongoing analysis and trending of specific data indicators related to the health status of the Medicaid population. This may include issues involving access, quality or utilization.

Studies

Based upon the findings of surveys, complaints, utilization review or indicator analysis, further analysis may occur through implementation of a focused study. Studies will pertain to issues relevant to the Medicaid population and may include topics such as prenatal care, access, immunizations, pediatric asthma, or KBH. Individual Medicaid providers may have the opportunity to participate in these study processes thereby gaining knowledge of their own practices and assisting in shaping the future of quality in the Medicaid program.

Education

As a result of findings through indicator analysis, surveys, complaints or studies, Medicaid will initiate education specifically targeted to the population most affected. This includes both providers and member. It is the intent that through positive educational efforts and encouragement of continuous quality improvement for individual provider practices, punitive program actions may significantly decrease.

2400. Updated 06/21

Solicitation by Provider
KMAP does not allow any form of solicitation targeting physicians, mid-level practitioners, or members for services or supplies.

Ineligible Providers
An ineligible provider is defined as one who would not be eligible if application to be a provider was made, even though the service to be provided was covered. According to Kansas Administrative Regulation 30-5-67, KMAP shall not reimburse for claims generated by certain ineligible providers. Services ordered, prescribed, or performed by ineligible providers are not billable to KMAP and will not be reimbursed.

Excluded Providers
An excluded provider is an individual or entity who has been excluded/sanctioned/debarred from doing business with any agency or department of the United States Government or any program which receives federal funding. This exclusion is applicable to KMAP/KanCare since it is funded in part by the United States Government. The effect of this exclusion is the prohibition of any payment for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Compliance with federal regulation guidance requires both individuals and entities be screened on a monthly basis.

Who is to be screened each month?
The regulations outline providers who furnish, order, or prescribe services may not be excluded individuals or entities. The term "providers" applies not only to individuals and entities who may be rendering direct patient care such as physicians and nurses but also in-direct providers such as administrative and management employees, business owners, and third-party vendors who directly or indirectly furnish services payable by a federally funded program. Some examples are given below.

- A driver as well as a dispatcher employed by a transportation company who serves KanCare members may not be an excluded individual.
- The vendor used to supply surgical trays to a hospital who serves KanCare members may not be an excluded entity.
- A nurse rendering direct patient care and a temporary nurse furnished by a staffing agency may not be an excluded individual.
- A personal care worker may not be an excluded individual.

Once an individual or entity is excluded, the individual or entity may not participate in the KMAP/KanCare program no matter what role is taken. For example, an individual is excluded while employed as a nurse in California. After the exclusion, the individual moves to Kansas and opens a home care business. This business would not be eligible for participation in KMAP/KanCare because the owner is an excluded individual. Additional information and examples can be found in the **Special Advisory Bulletin on the Effective of Exclusion from Participation in Federal Health Care Programs** published by the HHS/OIG. The document is available on the OIG website.

Where can information on excluded individuals and entities be found?
The Office of Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS) has the authority to exclude individuals and entities from federally funded health care programs. Additional information on HHS/OIG exclusions can be found on the Exclusions Program page of the OIG website. This webpage contains a link to an on-line search.

2400. Updated 06/21

Who is to be screened each month? continued

The System for Award Management (SAM) refers to a website maintained by the General Services Administration of the U.S. Government. It can be searched to find individuals and entities excluded from doing business with the federal government. HHS/OIG exclusions are contained within the SAM database along with other individuals and entities excluded by other federal government agencies. (This database was formerly known as the EPLS - Excluded Parties List System.) The SAM list is available on the SAM website.

Each state maintains a list of providers terminated from its Medicaid program. The list for Kansas can be found on the KDHE website.

Best practices

- Establish policies to require screening of prospective and current employees and vendors for exclusions.
- Establish policies to be followed when an exclusion is identified.
- Communicate policies regarding screening for and reporting of exclusions to employees and vendors.
- Conduct pre-employment screening of potential employees to include a search of the exclusion lists and retain the documentation supporting the screening process was completed and the results of the screening.
- Conduct screenings of any third-party vendors against the exclusion lists prior to doing business with the vendor and retain the documentation supporting the screening process was completed and the results of the screening.
- Check current employees and vendors against the exclusion lists on a monthly basis and retain the documentation supporting the screening(s) were completed and the results of the screening(s).
- Self-report any exclusions found, and action taken to Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF).

How to self-disclose an exclusion

Any relationships identified with an excluded entity are to be reported. This information can be disclosed to the address below.

ATTN: Fraud/Utilization Review Manager
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Suite 900 N
Topeka, Kansas 66612-1220

If the excluded entity is an individual, as much of the information below should be included:

- Individual name
- Social Security number
- National Provider Identifier (NPI)
- Date of birth
- Role
- Dates of contact with the excluded individual

2400. Updated 06/21

Who is to be screened each month? continued

If the excluded entity is an organization or business, as much of the information below should be included:

- Organization/business name
- Tax ID/EIN
- NPI
- Role
- Dates of contact with the excluded entity

Fraud and Abuse

Member

Suspected cases of member fraud (including the abuse of the medical ID card) should be immediately reported to KMAP Customer Service at 1-800-933-6593.

Lock-in (Member Restriction)

Members found to be abusing their medical coverage through a review of Medicaid claim history are educated as to more appropriate behavior. If abuse continues, members are restricted to a specific provider(s) for a period of two years. This process is known as lock-in. If abusive patterns continue during the two-year period, or the member had previously been on lock-in, lock-in will be extended for an indefinite period of time. KDHE-DHCF may place members on lock-in without education based on the severity of the abuse.

Normally a member will be locked-in to a pharmacy, physician, and/or hospital. In some cases, the member may be locked-in to all of these. Lock-in information is available through BEVS via AVRS or POS system. See **Section 2000** of this manual for complete information on eligibility verification.

When a provider believes a member is abusing the program by over-using (requesting services the provider deems not to be medically necessary, "doctor-hopping", or any excessive use of doctors, hospitals, emergency rooms, or drugs), it is requested that the provider assist the state agency in controlling such abuse. The provider can confront the member about unacceptable behavior, or the provider can choose to notify KDHE-DHCF of the abuse.

Abuse situations can also be communicated to:

KDHE-DHCF
900 Southwest Jackson, Room 900
Topeka, Kansas 66612
785-296-3981
Welfare Fraud Hotline 1-800-432-3913

2400. Updated 06/21

Fraud and Abuse continued

Lock-in Pharmacy
The lock-in pharmacy is responsible for verifying that the prescribing physician is the lock-in physician. If that the prescribing physician is not the lock-in provider, the pharmacy must obtain a copy of the written referral given to the prescribing physician by the lock-in physician. A copy of the written referral must be kept in the pharmacy and be available upon request by KDHE-DHCF personnel.

When a lock-in pharmacy cannot fill a prescription (for example, out of stock), then the lock-in pharmacy must write a referral to another pharmacy to fill the prescription. This should be an exception and not be done on an on-going basis.

Lock-in Physician
The lock-in physician's role is similar to the PCCM in that a written referral is required from the lock-in physician before any other physician or specialist can be paid for services rendered. A month referral is allowed versus a six-month referral. A referral to the same provider specialty may occur only if the lock-in physician does not have an appointment time available or is out of the office, such as vacation. A lock-in physician cannot refer to another physician to fulfill case management requirements.

Lock-in is initiated as a result of abuse of the medical card and may be initiated in any county. A case management fee is paid monthly to the lock-in physician. When a member is placed on lock-in, in most cases, the PCCM is retained as the lock-in physician and a case management fee is paid to the physician for the lock-in status.

Lock-in Hospitals
When a member is locked-in to a hospital, the member should use only that lock-in hospital. In a nonemergency situation, there must be a written referral from the lock-in physician for outpatient services. Emergency situations do not require a referral.

Also, if the member goes to a non-lock-in outpatient hospital for a nonemergency diagnosis, that outpatient hospital will not be paid. (The emergency room charge will not be paid for a nonemergency diagnosis regardless of the lock-in status.)

Referral Requirements
When a member is placed on lock-in, a written referral from the lock-in provider is required before another provider can be reimbursed for services rendered.

The written referral must be retained in the referred provider's office and in the pharmacy and must be furnished on request. The referral must be dated and is only valid for one month immediately following its issue.

2400. Updated 06/21

Billing Instructions
Services rendered by any provider in the event of a true **emergency** will be covered if documented appropriately.

Pharmacy:	Enter the lock-in physician's Kansas Medicaid provider number or National Provider Identifier (NPI) in the prescribing physician field for point-of-sale claims if the lock-in provider is the prescribing physician.
Physician:	Enter the KMAP lock-in provider number in field 17A of the CMS 1500 Claim Form **unless** the billing/performing provider is the lock-in provider or filing claims for radiologists or pathologists.
Hospital:	Enter the KMAP lock-in physician's provider number in FL 76 of the UB-04 claim form.

Provider
The Medicaid Fraud and Abuse Division of the Office of the Kansas attorney general is responsible for the investigation and prosecution of provider fraud. All cases of suspected fraud should be reported immediately to the Division for investigation. Referrals can be made at any time by contacting the Division at 785-368-6220.

Prosecution will be under applicable state and/or federal law. Conviction can result in punishment that includes full restitution of the excess payments, payment of interest, payment of reasonable expenses and the costs of the investigation and prosecution, payment of fines and penalties, and imprisonment. The Division will also request KDHE-DHCF to take action to terminate provider participation in the Medicaid program.

Determination by the agency that abuse, or fraud of the Medicaid program has occurred may result in suspension of payment, prepay review of claims, recoupment of monies, or termination of the provider's eligibility to participate in the Medicaid program.

Complaint/Grievance Process
Medicaid members and providers who have concerns regarding access to care, utilization of services, quality of services, or rights and dignity can contact the fiscal agent at 1-800-933-6593 between 7:30 a.m. - 5:30 p.m., Monday through Friday. Concerns will be carefully evaluated and directed to the appropriate staff for research, follow-up, and action if needed. You will be notified of the outcome.

If you have a concern about the health care provided to a Medicaid member or the quality of health care services of another provider, notify the fiscal agent at the number above.

For issues concerning potential member fraud, contact KMAP Customer Service at 1-800-933-6593.

2410. GUIDELINES FOR THE CHRONIC USE OF OPIOID PRODUCTS Updated 06/21

The **Opioid Products Indicated for Pain Management** prior authorization (PA) criteria for Medicaid members are found on the Kansas Department of Health and Environment (KDHE) website.

The Opioid Products Indicated for Pain Management Prior Authorization Form is located on the KDHE website.

2500. STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH PROVIDERS

Updated 06/21

Providers of services and supplies to members must comply with all laws of Kansas and the regulations and policies of KDHE-DHCF and the standards or ethics of their business or profession to qualify as a participant in the program. The State Medicaid director or his/her designee may notify a provider of the intent to discontinue a provider's participation in KMAP.

Upon notification of intent to withdraw payment liability for services rendered, or to terminate participation in KMAP, the provider of services has the opportunity for an administrative review. If after the administrative review, the provider continues to disagree with the determination, a subsequent fair hearing may be requested with a hearing officer at KDHE-DHCF.

Kansas Administrative Regulation 30-5-60 states in part that the agency may terminate a provider's participation in KMAP for one or more of the following reasons:

- Pattern of submitting inaccurate billings or cost reports
- Pattern of unnecessary utilization
- Civil or criminal fraud against KDHE-DHCF or Social Service Programs or any other state's Medicaid or Social Service Programs
- Suspension by the secretary of Health and Human Services from the Title XVIII program for any reason
- Direct or indirect ownership or controlling interest of five percent or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the Medicare program or KMAP or Social Service Programs or any other state's Medicaid or Social Service Programs
- Employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the Medicare program or KMAP or Social Service Programs or any other state's Medicaid or Social Service Programs and other "good cause"

2600. REPORTING OF ABUSE, NEGLECT, OR EXPLOITATION OF CHILD OR RESIDENT IN LICENSED CARE FACILITY REQUIRED Updated 02/18

Who Must Report:

- Any person licensed to practice any branch of the healing arts
- The chief administrative officer of a medical care facility
- An adult care home administrator
- A licensed social worker
- A licensed professional nurse
- A licensed practical nurse
- Any other person having reasonable cause to suspect or believe that a child or licensed care facility resident is being or has been abused, neglected, exploited or is in a condition which is the result of such abuse, neglect, exploitation or is in need of protective services.

How to Report

Call the Kansas Department for Aging and Disability Services (**KDADS)** at **1-800-842-0078** regarding reports of abuse, neglect, or exploitation in an adult care facility, medical care facility, or home health agency, go in person, or write the local KDADS office.

KDADS
New England Building
503 South Kansas Avenue
Topeka, KS 66603

Call **DCF** at **1-800-922-5330** regarding abuse, neglect or exploitation occurring domestically or in the community, go in person, or write the local DCF office.

DCF
Prevention and Protection Services
555 South Kansas Avenue
4th Floor
Topeka, KS 66603

What Must Be Reported

- Information regarding the nature and extent of the abuse or neglect
- Name and address of the involved resident or child
- Name and address of the caretaker caring for the resident or child
- Name and address of the person making the report
- Name of next of kin of the resident or child, if known
- Any other information which the person making the report believes might be helpful in any investigation of the case and the protection of the resident or child

Immunity of Reporter

No person who makes such a report or who testifies in any administrative or judicial proceeding arising from such report shall be subject to any civil liability on account of such report or testimony, unless such person acted in bad faith or with malicious purpose.

No employer shall terminate the employment of, prevent or impair the practice or occupation of or impose any other sanctions on any employee solely for the reason that such employee made or caused to be made such a report.

2700. DOCUMENTATION REQUIREMENTS Updated 06/21

Claim/Record Storage Requirements

K.S.A. 21-5931 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer-generated invoicing.

Providers who submit claims through computerized systems must maintain these records in a manner which is retrievable.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers:

- To keep such records as necessary to disclose fully the extent of services rendered to members
- To furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider

Providing medical records to KDHE-DHCF or its designee is not a billable charge.

Advance Member Notice for Fee-For-Service Medicaid Program

The KMAP member can be held responsible for payment of common services and situations. Members can be billed only when program requirements have been met and the provider has informed the member in advance and in writing. The provider must notify the members in advance if a service will not be covered. To ensure the member is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Member Notice (ABN) from the member prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.

> K.A.R. 30-5-59, "…(e) Payment. Each participating provider shall meet the following conditions: (4) not charge any Medicaid/Medikan program member for non-covered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for non-covered services;"
>
> **Suggested content for the Advance Member Notice**
>
> This constitutes advance notice to you, the members, that if all program requirements are met by (the provider) and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid.

For services where there is normally no face-to-face contact between the member and the provider (examples are lab and radiology services), the written ABN signed annually by the members with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

- Member was not eligible when services were provided.
- Member was eligible when services were provided, however, did not inform the provider of his or her KMAP eligibility timely. (This action must have prevented the provider from filing services to the program within the timely filing guidelines outlined in **Section 5100** of the *General Billing Fee-for-Service Provider Manual*).

2700. Updated 06/21

Advance Member Notice for Fee-For-Service Medicaid Program continued

- Services Medicaid does not cover, unless both of the following apply:
    - Member is a QMB
    - Service is covered by Medicare
- When other insurance does not reimburse the provider because there was lack of authorization.
- Abortions, unless continuation of the pregnancy will endanger the life of the mother, or when a pregnancy is the result of rape or incest.
- Any services related to and performed **following** a noncovered abortion.
- Acupuncture.
- Community mental health center services and alcohol and drug abuse treatment services provided outside the boundaries of Kansas regardless of being within 50 miles of the state border.
- Cosmetic surgery.
- Services related to and performed **following** a noncovered cosmetic surgery.
- Court appearances, telephone conferences/therapy.
- Educational/instructional services.
- Hospital charges incurred after the physician has discharged the patient from inpatient care.
- Hypnosis, biofeedback, or relaxation therapy.
- Infertility services (any tests, procedures, or drugs related to infertility services).
- Occupational therapy supplies.
- Perceptual therapy.
- Psychotherapy for patients whose only diagnosis is mental retardation.
- Services for the sole purpose of pain management.
- Services provided in cases of developmental delay for purposes of "infant stimulation."
- Services which are pioneering or experimental, and complications from such services.
- Services of social workers and team or therapy coordinators in private practice (unless member is a QMB).
- Transplant surgery.
    - All services related solely to noncovered transplant procedures.

  Note: Transplant surgery, in some cases, is a covered service for a KMAP member. Call Customer Service for a list.
- Treatment for obesity. **Exception:** Certain medications used for weight loss may be considered for coverage with prior authorization. Reference the Prior Authorization - Clinical Criteria page on the KDHE website for the PA criteria and medications considered for coverage.
- Vocational therapy, employment counseling, marital counseling/therapy and social services.
- Voluntary sterilizations which do not meet federal requirements.
- Services provided to a MediKan member in the following program areas: alcohol and drug addiction treatment facility, behavior management, chiropractic, dental, Head Start facility, Local Education Agency, nonemergency and non-ambulance medical transportation, podiatry, and vision.
- The private room difference in a hospital setting.
- Special diet in the hospital when ordered per the patient's request.

Providers are not to charge a KMAP member for services denied for payment by KMAP because the provider has failed to meet a program requirement including PA.

2700. Updated 06/21

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

***Note*: Providers shall not bill members for missed appointments. Missed appointments are not a distinct reimbursable service but a part of the providers' overall cost of doing business.**

Documentation Requirements
As with all other insurance carriers, Medicaid has specific requirements regarding documentation of services performed and billed to KMAP. These requirements are within the standards of each professional scope of practice and are consistent with requirements of other major insurance carriers. The following information regarding documentation requirements is not new but is provided as education so each provider can ensure all services billed to Medicaid are medically necessary and have been provided as billed.

- The patient record shall be legible and **stand on its own**.
- The date and reason for a service must be included.
- Extent of the patient history and exam must be documented along with a treatment plan.
- Documentation must support the level of service billed.
- Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp which reflects results of the exam for each of the systems identified on the rubber stamp.
- Unless permitted by specific HCBS program guidelines, **check marks are not accepted**.
- Records must be created **at the time the service is provided**.
- All written and computerized physician order entry (CPOE) verbal or telephone orders must be authenticated within 72 hours of discharge or 30 days, whichever occurs first. To authenticate handwritten orders, documentation must include the date, time, authorized signature, and associated credentials. Billing for services must occur only after documentation is authenticated.

Progress notes must include:

- Chief complaints or presenting problems
- Type of history
- Extent of services
- Patient progress and response to treatment
- Evidence of the type of decision made which includes, but is not limited to:
    - Diagnoses
    - Treatment options
    - Extent of data reviewed
    - Risk of morbidity and mortality

The following questions should be asked to ensure appropriate documentation exists to support the level of service billed:

- Is the reason for the visit documented in the patient record?
- Are all services that were provided documented?
- Does the patient record clearly explain why support services, procedures, supplies and medications were or were not provided?
- Is the assessment of the patient's condition apparent in the record?

2700. Updated 03/18

Documentation Requirements continued

- Does documentation contain information on the patient's progress and results of treatment?
- Does the patient record include a plan for treatment?
- Does information in the patient record provide medical rationale for the services and the place of service that are to be billed?
- Does information in the patient record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services? Is there documentation of timely referrals?

Recordkeeping responsibilities rest with the provider. When a service is not documented or documentation is not legible, the service is not reimbursed.

Electronic Documentation Signature

Electronic signatures that meet the following criteria are acceptable for Medicaid documentation:

- Identify the individual signing the document by name and title
- Include the date and time the signature is affixed
- Assure the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence
- Provide for nonrepudiation, that is, strong and substantial evidence that will make it difficult for the signer to claim the electronic representation is not valid

The use of an electronic signature is deemed to constitute a signature and has the same effect as a written signature on a document. The provider must have written policies and procedures in effect regarding the use of electronic signatures. In addition to complying with security policies and procedures, the provider who uses computer keys of electronic signatures must sign a statement assuring exclusive access and use of the key or computer password. The policies and procedures and statement of exclusive use must be maintained at the provider's location and available upon request by the State or fiscal intermediary.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance will result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.

Original signatures are required on the Provider Agreement when the KMAP provider enrollment application is submitted on paper.

Electronic Documentation

Electronic documentation that meets the following criteria is acceptable for Medicaid:

- Meet all documentation and signature requirements contained in this manual
- Meet all documentation and signature requirements specific to the KMAP program and services provided
- Assure the documentation cannot be altered once entered
- Maintain a system to record all activity that occurs within the EHR system including username and documentation of event description such as amendment, correction, or deletion – with date and time. The EHR system audit log must be operational at all times and available upon request.

2700. Updated 09/22

Electronic Documentation continued
Providers must have written policies and procedures in effect regarding the use of electronic documentation that must be maintained at their location and available upon request by the State or fiscal intermediary. These requirements for clinical documentation apply only to Medicaid claims and do not preclude other state or federal requirements.

Electronic records, as with all forms of documentation, must be valid, accurate, complete, trustworthy, and timely. Tools available to increase clinician efficiency must be used in a manner which ensures documentation integrity. Examples include:

- Use of templates (also known as default features, self-populating fields, etc.) must be modified to contain data which is accurate and complete as it pertains to each individual visit while all irrelevant data is removed. For example, the automatic generation of common negative findings within a review of each body area or organ system may result in a higher level of service than provided, unless the provider documents any pertinent positive results and deletes the incorrect auto-generated entries. Automated insertion of data when not modified to be patient-specific and pertinent to the visit will result in recoupment of payment(s).
- Use of cloned documentation (also known as copy and paste, "make me the author" functionality, etc.) must contain data which is accurate and complete as it pertains to each individual visit with all irrelevant data removed. For example, the cloning of documentation from visit to visit or patient to patient (vital signs that never change, prostate exam on a female patient) may result in inaccurate information unless the provider deletes the incorrect cloned documentation. Cloned documentation not modified to be patient-specific and pertinent to the visit will result in recoupment of payment(s).

Refer to the Program Integrity: Electronic Health Records page on the CMS.gov website for additional assistance to ensure the proper use of EHR features and capabilities.

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance will result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.
Note: Documentation can be requested at any time to verify that services have been provided within program guidelines.

In the case of a postpayment review, reimbursement is recouped if documentation is not complete or does not meet the general documentation requirements provided in this manual and the requirements specific to the KMAP program and services provided. Refer to the provider-specific manual, including its benefits and limitations section and recordkeeping requirements, for additional documentation requirements.

To verify services provided in the course of a postpayment review, documentation in the member's medical record must support the level of service billed. Documentation for the HCBS program must validate services billed were provided in accordance with the plan of care. Documentation for any KMAP program created after the fact is not accepted in a postpayment review.

The Medical Attestation Form is required for Medicaid members to participate in clinical trials as per Section 210 of the Consolidated Appropriations Act of 2021 from the Centers for Medicare and Medicaid

2700. Updated 09/22

Electronic Documentation continued
Services (CMS). The Medical Attestation Form can be found here under the forms section on the KMAP Portal. Providers should retain the completed form in their patient file.

2710. GENERAL THERAPY GUIDELINES AND REQUIREMENTS Updated 06/21

Therapy Guidelines and Requirements
Therapy services are covered when they are:

- Prescribed by a physician, as required by your license/certification.
- Medically necessary.
- **Habilitative** - Habilitative therapy is covered only for members aged zero to under the age of 21. Therapy treatments approved and provided by an ECI, Head Start or LEA program may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to maintain maximum possible functioning for children. LEAs billing for occupational, physical, or speech therapy must have the ordering, referring, or prescribing provider's NPI on the claim. This provider must be enrolled with KMAP on the date of service.

Developmental Therapy Services
Medicaid covers developmental physical therapy, developmental occupational therapy, and developmental speech therapy services for children under 21 years of age. Individuals can receive developmental therapy services to treat autism spectrum disorders (ASDs), birth defects, and other developmental delays in any appropriate community setting from any qualified provider with PA and medical necessity documentation.

Coverage will be available for the diagnosis and treatment of ASD. Diagnosis must be established using an appropriate assessment instrument and performed by an appropriately licensed medical provider. Services must be preapproved and may include developmental speech therapy, developmental occupational therapy, or developmental physical therapy as appropriate. An initial comprehensive assessment to establish a baseline must be completed. Periodic re-evaluations and assessments are required at least every six months and continuous improvement must be shown to qualify for continued treatment.

The provision of services for all children with birth defects and developmental delays, which include ASDs, will be allowed by any qualified provider in any appropriate place of service. The services will include developmental physical therapy, developmental occupational therapy, and developmental speech/language pathology services as documented in a comprehensive treatment plan. A treatment plan means a submission by a provider or group of providers, signed by both the provider(s) and parent(s)/caregiver(s), that includes:

- The type of therapy to be administered and methods of intervention
- The goals: including specific problems or behaviors requiring treatment, frequency of services to be provided, frequency of parent or caregiver participation at therapy sessions, description of supervision, periodic measures for the therapy, and frequency at which goals will be reviewed and updated
- Who will administer the therapy
- The patient's current ability to perform the desired results of therapy

2710. Updated 06/21

Therapy Guidelines and Requirements continued

The following diagnosis codes will not be accepted as a primary diagnosis:

- R62.50: Unspecified lack of expected normal physiological development in childhood
- R62.59: Other lack of expected normal physiological development in childhood
- R68.89: Other general symptoms and signs

Note: These services require a PA be on file for payment regardless of what the KMAP website HCPCS Code Search page displays.

- **Rehabilitative** - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following debilitation due to an acute physical trauma or illness.
- Physical therapy must be provided by a licensed physical therapist or certified physical therapy assistant working under the supervision of a licensed physical therapist.
- Occupational therapy must be provided by a licensed occupational therapist or certified occupational therapy assistant working under the supervision of a licensed occupational therapist.
- When services are performed by a certified therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed physical or occupational therapist initialing each treatment note written by the certified therapy assistant of their discipline, or the licensed therapist writing "Treatment was supervised" followed by his or her signature.

Therapy services are limited to six months for members over the age of 21 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for members aged zero to 21.

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

Documentation requirements of therapy services:

- Pertinent past and present medical history with approximate date of diagnosis
- Date, time, and description of each service delivered and by whom (name, designation of profession or paraprofession)
- Identification of expected goals or outcomes and member's response to therapy
- Progress towards goals

Refer to the specific provider manual for additional benefits and limitations.

Provisions in the Kansas Telemedicine Act will allow speech-language pathologists and audiologists licensed by KDADS to provide services via telemedicine. Services must be provided via real-time, interactive (synchronous) audio-video telecommunication equipment that is compliant with HIPAA.

2710. Updated 06/23

Therapy Guidelines and Requirements continued
The speech-language pathologist and audiologist may furnish appropriate and medically necessary services within their scope of practice via telemedicine. As documented in related telemedicine policies, telemedicine claims at the distant site must contain place of service 02 (Telehealth distant site). Providers at the originating site may submit claims using code Q3014 (Telehealth originating site facility fee).

- Distant site means a site at which the healthcare provider is located while providing healthcare services by means of telemedicine.
- Originating site means a site at which a patient is located at the time healthcare services are provided by means of telemedicine. The facilitator at the originating site must have the appropriate skill set to safely assist the speech-language pathologist or audiologist to provide safe, effective, and medically necessary services via telemedicine.

The following codes are deemed appropriate to be furnished via telemedicine by the American Speech-Language and Hearing Association. Codes not appearing on the tables below are not covered via telemedicine.

Note: The GT modifier is no longer required when billing telemedicine services.

Speech-Language Pathology Codes

92507	92508	92521	92522	92523	92524	92526	92605
92606	92618	92626	92627	92630	92633	96105	96110
96112	96113	96125	97129	97130	97533		

Audiology Codes

92550	92551	92552	92553	92555	92556	92557	92563
92565	92567	92568	92584	92586	92587	92601	92602
92603	92604	92625	~~92858~~	~~0725T~~	~~0726T~~	~~0727T~~	0728T
0729T							

2720. TELEMEDICINE Updated 01/23

Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.

Office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider at the distant site must bill an appropriate code from the list below with place of service (POS) 02 - Telemedicine and will be reimbursed at the same rate as face-to-face services. The GT modifier is not required when billing for telemedicine services. The originating site, with the member present, may bill code Q3014 with the appropriate POS code.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90847	90863	90951
90952	90954	90955	90957	90958	90960	90961
92227	92229	92228	96116	97802	97803	99202
99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233
99304	99305	99306	99307	99308	99309	99310
99366	99367	99368	99406	99407	99408	99409
99495	99496	G0406	G0407	G0408	G0425	G0426
G0427	G0508	G0509	H0001	H0004	H0005	H0006
H0007	H0031HO	H0032HA	H0038	H0038Q	H2011HO	H2011U1
T1030**	T1031**					

****Telehealth only**

KMAP does not recognize AMA *CPT* consultation codes 99242, 99243, 99244, 99245, 99252, 99253, 99254, and 99255 for payment.

The Kansas Telemedicine Act will be enacted in accordance with Senate Substitute for House Bill No. 2028.

Definitions:

- "Distant site" means a site at which a healthcare provider is located while providing healthcare services by means of telemedicine.
- "Healthcare provider" means a physician, licensed physician assistant, licensed advanced practice registered nurse or person licensed, registered, certified, or otherwise authorized to practice by the behavioral sciences regulatory board.

2720. Updated 10/18

Definitions continued:

- "Originating site" means a site at which a patient is located at the time healthcare services are provided by means of telemedicine.
- "Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.
- "Telemedicine", including "telehealth", means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine will be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's healthcare.

Telemedicine does not include communication between:

1. A healthcare provider that consists solely of a telephone voice-only conversation, email, or facsimile transmission.
2. A physician and a patient that consists solely of an email or facsimile transmission.

Patient privacy and confidentiality:

The same requirements for patient privacy and confidentiality under HIPAA of 1996 and 42 C.F.R. § 2.13, as applicable, that apply to healthcare services delivered through in-person contact also apply to healthcare services delivered through telemedicine. Nothing in this section supersedes the provisions of any state law relating to the confidentiality, privacy, and security or privileged status of protected health information (PHI).

Requirements regarding the provision telemedicine services:

1. Telemedicine may be used to establish a valid provider-patient relationship.
2. The same standards of practice and conduct that apply to healthcare services delivered through personal contact also apply to healthcare services delivered through telemedicine.
3. A person who is authorized by law to provide and provides telemedicine services to a patient must provide the patient with guidance on appropriate follow-up care.
4. Except when otherwise prohibited by any other provision of law, when the patient consents and has a primary care or other treating physician, the person providing telemedicine services will send within three business days a report to such primary care or other treating physician of the treatment and services rendered to the patient in the telemedicine encounter.
5. A person licensed, registered, certified, or otherwise authorized to practice by the Behavioral Sciences Regulatory Board will not be required to comply with the provisions of requirement #4 (above).
6. The provisions of this section shall also apply to the Kansas Medical Assistance Program (KMAP).
7. KMAP will not exclude an otherwise covered healthcare service from coverage solely because such service is provided through telemedicine, rather than through personal contact, or based upon the lack of a commercial office for the practice of medicine.
8. The insured's medical record will serve to satisfy all documentation for the reimbursement of all telemedicine healthcare services, and no additional documentation outside of the medical record will be required.
9. Payment or reimbursement of covered healthcare services delivered through telemedicine is the payment or reimbursement for covered services that are delivered through personal contact.

2720. **Updated 06/21**

Requirements regarding the provision telemedicine services continued:

10. Services provided through telemedicine must be medically necessary and are subject to the terms and conditions of the individual's health benefits plan.
11. KMAP cannot require a covered individual to use telemedicine in lieu of receiving an in-person healthcare service or consultation from an in-network provider.
12. Nothing in the Kansas telemedicine act shall be construed to authorize the delivery of any abortion procedure via telemedicine.

Note: As documented in related telemedicine policies, telemedicine claims at the distant site must contain place of service 02 (Telehealth distant site). Providers at the originating site **are required** to submit claims using code Q3014 (Telehealth originating site facility fee).

Providers must ensure the codes are covered by KMAP. Providers may only furnish telemedicine services that are safe, medically necessary, and within the provider's specified scope of practice.

LIMITATIONS

- The patient (member) must be present at the originating site.
- Email, telephone, and facsimile transmissions are not covered as telemedicine services.
- Documentation requirements are the same as face-to-face services, see **Section 2710**.

2800. HOSPICE Updated 06/21

Hospice provides an integrated program of appropriate hospital and home care for the terminally ill patient. It is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. A hospice provides personal and supportive medical care for terminally ill individuals and supportive care to their families. Emphasis is on home care with inpatient beds serving as backup for the Home Care Program. Central to the hospice philosophy is self-determination by the patient in medical treatment and manner of death.

Hospice Limitation
An individual can elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

Waiver of Rights to Medicaid Payment
The member waives all rights to Medicaid/MediKan payments for the duration of the election of hospice care for any Medicaid/MediKan covered services that are either:

- Related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Equivalent to hospice care **except** for services:
    - Provided directly or under arrangement by the designated hospice
    - Provided by another hospice under arrangement by the designated hospice
    - Provided by the member's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services

Services Not Related to the Terminal Illness
Services normally covered under KMAP require PA when the member is a hospice member, and the service does not relate to the terminal illness. Refer to **Section 4300** of the *General Special Requirements Fee-for-Service Provider Manual* for information on obtaining PA.

Note: Hospice providers will not be required to obtain PA for targeted case management (TCM) when a member elects hospice service. Members receiving hospice services may also be eligible to receive services through the HCBS program. However, HCBS may not duplicate services being rendered by the hospice provider.

To ensure services are not duplicated and the hospice member is receiving the quality of care that he or she is entitled to, KMAP may ask for written care plans from hospice and HCBS providers. Hospice is the coordinator of all care services that the hospice member receives. When a member is admitted to hospice services while receiving TCM services, providers do not need to obtain PA for TCM services. Care coordination provided through the hospice benefit and TCM are separate and distinct services and are not duplicative.

2800. **Updated 06/21**

Hospice Care for Children in Medicaid
Members receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Limitations
Concurrent hospice care for children will be covered for the duration needed. An individual may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

Medical Services and Concurrent Care for Children Receiving Hospice Services
Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- PA is required.
- Hospice providers will be responsible for coordinating all services related to the hospice diagnosis and assisting nonhospice providers to obtain authorization for services not related to the hospice diagnosis in accordance with 42 Code of Federal Regulations 418.56.
- Hospice providers will be responsible for all durable medical equipment, supplies, and services related to the hospice diagnosis.
- Nonhospice providers must first communicate and coordinate with hospice providers regarding needed services or procedures prior to rendering concurrent care for children.
- Nonhospice providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, nonhospice providers must submit a paper claim, documentation of medical necessity and the hospice denial form to the PA department for review.
- If PA cannot be obtained prior to rendering services to children, providers may be allowed a backdated approval for services upon submission of a paper claim for the service with documentation attached to support medical necessity and hospice denial of the service.

Hospice patients (0 through 20 years of age) can receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an APRN enrolled in KMAP
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all durable medical equipment and supplies.

2910. IMMUNIZATION ADMINISTRATION Updated 04/23

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

Note: Use the following resources to determine coverage and pricing information. For accuracy, use the specific provider type and specialty as well as the member ID number or benefit plan.

- Information is available on the public website.
- Information is available on the secure website under Pricing and Limitations.

For further assistance, contact the Customer Service at 1-800-933-6593.

COVERAGE INDICATORS

ADLT	Vaccine covered for adults (19 years of age and older)
VFC	Vaccine covered by VFC (18 years of age and younger)
N/A	Not Applicable

ADMINISTRATION CODES

Coverage	Code		Coverage	Code
	0001A			0083A
	0002A			0091A
	0003A			0092A
	0004A			0093A
	0011A			0094A
	0012A			0111A
	0013A			0112A
	0031A			0113A
	0034A			0124A
	0041A			0134A
	0042A			0144A
	0044A			0154A
	0051A			0164A
	0052A			0173A
	0053A			0174A
	0054A			90471
	0064A			90472
	0071A			90473
	0072A			90474
	0073A			M0201
	0074A			
	0081A			

2910. IMMUNIZATION ADMINISTRATION Updated 04/23

VACCINE CODES

Coverage	Code		Coverage	Code
	90622		VFC	90723
ADLT	90632		VFC, ADLT	90732
VFC	90633		VFC	90733
VFC	90634		VFC, ADLT	90734
ADLT	90636		ADLT	90736
VFC	90644		ADLT	90739
VFC	90645		ADLT	90740
VFC	90646		VFC	90743
VFC	90647		VFC	90744
VFC	90648		ADLT	90746
VFC, ADLT	90649		ADLT	90747
VFC, ADLT	90650		VFC	90748
VFC	90651		ADLT	90759
VFC, ADLT	90653		N/A	91300
VFC	90654		N/A	91301
VFC	90655		N/A	91303
VFC, ADLT	90656		N/A	91304
VFC	90657		N/A	91305
VFC, ADLT	90658		N/A	91306
VFC, ADLT	90660		N/A	91307
VFC	90669		N/A	91308
VFC, ADLT	90670		N/A	91309
VFC, ADLT	90672		N/A	91311
VFC	90680		N/A	91312
VFC	90681		N/A	91313
VFC	90685		N/A	91314
VFC, ADLT	90686		N/A	91315
VFC	90687		N/A	91316
VFC, ADLT	90688		N/A	91317
VFC	90696		VFC	Q2035
VFC	90697		VFC	Q2036
VFC	90698		VFC	Q2037
VFC	90700		VFC	Q2038
VFC	90702		VFC	Q2039
VFC	90703			
VFC, ADLT	90707			
VFC, ADLT	90716			
VFC	90720			