Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS Community Support Waiver

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PART II
HCBS COMMUNITY SUPPORT WAIVER
PROVIDER MANUAL

Section **Page**

FORMS: All forms pertaining to this provider manual can be found on the Kansas Medical Assistance Program (KMAP) public and secure portals Publications and Form.

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 (MCOs), reference the KanCare website. Contact the specific health plan for managed care assistance.

INTRODUCTION – COMMUNITY SUPPORT WAIVER

The Community Support Waiver is intended for individuals who meet the institutional level of care criteria for IDD services but require fewer supports than those available under the comprehensive HCBS IDD Waiver. The waiver is designed to serve individuals whose assessed needs can be safely and appropriately met within the legislatively established annual service expenditure limit. CSW provides essential home and community-based services and supports that promote community living, independence, and individual choice.

The CSW is founded on person-centered principles that support participant choice, self-determination, and community inclusion. Through the person-centered planning process, participants are empowered to identify and select the services and supports that best meet their individual needs, preferences, and goals. Participation in the Community Support Waiver is voluntary and based upon informed individual choice.

To enroll in the Community Support Waiver, an individual must meet IDD program eligibility requirements, satisfy institutional Level of Care criteria through the state-approved MFEI-IDD assessment process, and meet all applicable Kansas Medicaid financial eligibility requirements. Eligibility for waiver enrollment is subject to KDADS approval and available waiver capacity.

Eligible participants may receive one or more of the following Community Support Waiver services, as identified through assessment and documented in the participant's approved Person-Centered Service Plan (PCSP):

- Assistive Services
- Behavior Therapy
- Benefits Planning
- Career Exploration and Planning
- Family/Caregiver Support and Training
- Home and Environmental Modification Services (HEMS)
- Home Telehealth
- Individual Employment Support (IES) Services
- Individual-Directed Goods and Services
- Life Skills Services
- Medication Reminder Services
- Non-Medical Transportation (NMT)
- Occupational Therapy
- Personal Care Services
- Personal Emergency Response Services
- Physical Therapy
- Remote Support
- Respite Care
- Specialized Medical Equipment (SMES)
- Speech and Language Therapy
- Vehicle Modification Services (VMS)
- Financial Management Services (FMS)*

All HCBS Community Support waiver services require prior authorization through the Plan of Care (POC) process.

*When applicable to self-directed service delivery, refer to the *HCBS Financial Management Services (FMS) Provider Manual* for criteria and information.

ELIGIBILITY, ENROLLMENT AND SERVICE AUTHORIZATIONS

Providers of Community Support Waiver services must be enrolled with the Kansas Medical Assistance Program (KMAP) and obtain the necessary enrollment approvals before delivering CSW services. Access provider enrollment information on the Provider page of the KMAP portal.

General

- For all participants approved for Community Support Waiver services, the Managed Care Organization (MCO) shall issue service authorizations within seven (7) calendar days of receiving a complete Person-Centered Service Plan that identifies the participant's eligibility and authorized Community Support Waiver services.
- Participants who reach the annual Community Support Waiver expenditure limit may be disenrolled from the waiver upon review and approval by KDADS. Such disenrollment shall be reported using the discontinuation reason "Service Cap Reached" (T-MSIS Code CS). The code shall not be reported until the participant has met the annual waiver expenditure limit and KDADS has approved disenrollment from the waiver.

FUNCTIONAL ASSESSMENTS AND REASSESSMENTS

Functional Assessments

- All functional eligibility assessments shall be completed in accordance with KDADS-approved assessment policies and procedures.
- Functional assessments shall be conducted by qualified and trained Community Developmental Disability Organization (CDDO) assessors using the state-approved MFEI-IDD assessment instrument.
- Functional eligibility determinations shall be made by KDADS, communicated to the Kansas Department of Health and Environment (KDHE), and confirmed at least annually for individuals receiving Community Support Waiver services.
- Functional assessments shall be conducted in person at a location selected by the individual. If available and preferred by the individual being assessed, assessments may be completed through real-time interactive tele-video communication technology.
- Upon completion of the initial assessment and each annual reassessment, the CDDO shall document that comprehensive options counseling has been provided to the individual. A signed statement acknowledging receipt of options counseling shall be maintained and provided to the participant's MCO.

Reassessments

- Persons with reasonable indicators of meeting level of care eligibility are evaluated upon initial application for services and then reevaluated annually, within 365 days of the last assessment. Reassessments shall include individuals not on the waiting list who are state funded and/or received a previous assessment determination of functional ineligibility.
- If a reassessment is desired outside of the annual assessment as prescribed above or the annual assessment is not required, the request for such special reassessment shall be provided to and reviewed by the HCBS CSW program manager prior to completion of the reassessment. The HCBS CSW program manager shall respond to each request within 10 business days from the date the request was received.

Recoupment

- KDADS shall conduct quality assurance reviews of functional assessments to ensure compliance with assessment requirements, assessor qualifications, documentation standards, and required assessment timelines.
- If a quality review determines that a functional assessment was not completed accurately or was not completed within required timelines, KDADS may recoup payments associated with the assessment. Recoupment may also occur when assessment documentation fails to support eligibility determinations or does not comply with KDADS-established requirements.
- CDDOs shall comply with all reporting requirements established by KDADS, including annual reporting related to assessment activity, assessor qualifications, and quality assurance monitoring.

Quality Assurance:

KDADS shall review a sample of completed functional assessments for completeness and accuracy. Quality assurance reviews will be conducted on the initial assessment and annual reassessments to ensure:

- The assessment tool was applied accurately.
- The initial assessment and annual reassessments were conducted within the specified timeline.
- The initial assessment and annual reassessments were conducted by a qualified assessor.
- The assessments submitted were completed correctly and addressed all required elements.

WAIVER ENROLLMENT

- The Community Support Waiver operates under statewide enrollment limits established by KDADS. The waiver shall function under one of two enrollment statuses:
  - Capacity Available (active admissions)
    - New applicants may be enrolled upon KDADS approval.
- While capacity is available during the first three years, individuals who have been determined functionally eligible for IDD services may apply for or transition to the CSW.
  - The CDDO provides options counseling and submits the referral to KDADS for review.
  - KDADS verifies functional eligibility and available capacity.
  - If approved, KDADS issues the CSW 3160 to authorize enrollment.
  - KDHE completes the Medicaid financial eligibility determination following KDADS approval.

RESERVED CAPACITY

Capacity is reserved for the following populations:

- Persons in the custody of DCF may access CSW waiver program services for the purpose of addressing non-supervision support needs related specifically to a person's CSW diagnosis. In the event services are provided, the services shall not duplicate services already being provided, or services that should be provided, by the foster parent
- Persons meeting the criteria set forth in the KDADS "Military Inclusion" policy
- Persons transferring from a psychiatric residential treatment facility (PRTF) or other institutions
- Persons previously on the I/DD waiver or CSW transferring back to the CSW from the WORK program
- Persons no longer eligible for the Brain Injury Waiver
- Persons no longer eligible for the Autism Waiver
- Persons no longer eligible for the Technology Assisted Waiver
- Persons who had a temporary institutional stay
- Persons who are on the I/DD waiver

KDADS REVIEW PROCESS

Request Review

- The CSW program manager reviews all uploaded documentation provided by the CDDO.
- All documentation will be reviewed within 10 business days.

Determination

- Approval or denial documentation will be mailed to the address on file and emailed to the CDDO, DCF (if the person is in the custody of DCF), and MCO, if applicable. Form 3160 shall be completed and forwarded for all approvals.
- If the request is denied:
  - KDADS will provide the person and/or guardian, CDDO, MCO (if applicable), and DCF (if the person is in the custody of DCF) with a formal NOA indicating the services were denied and providing the person with their appeal rights.

Approval

- KDADS communicates its approval to the Kansas Department of Health and Environment (KDHE) Clearinghouse, CDDO, and MCO through the ES-3160.
- The KDADS CSW program manager sends a NOA approval to the person. A copy is also emailed to the CDDO and MCO, if applicable.

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF

- Any child determined eligible for HCBS CSW services who the court has found to be a child in need of care (CINC), has come into custody of the Secretary of DCF, and placed in a foster care living arrangement will not be placed on a waiting list and shall have access to the services required to meet their assessed needs. The approved HCBS CSW services will not duplicate services available through other resources.
- Access to services will not be available for the purpose of maintenance (including room and board) or supervision required to be provided in a family foster home for individuals who are in the custody of DCF.
- Agency-directed Supportive Home Care is considered the preferred in-home service delivery model for individuals in DCF custody.
- Member direction may be a necessary option for foster children receiving HCBS waiver services who have an identified need yet reside in a geographic area where there is little to no access to agency-directed Supportive Home Care.

Member Direction for Individuals in DCF Custody:

- Member direction of HCBS waiver services for individuals in DCF custody requires approval of an exception by the Program Manager of the applicable HCBS waiver. An exception may be granted by KDADS upon consultation with DCF and other applicable authorities. Therefore, the HCBS Program Manager will consult with the DCF Permanency Program Administrator and MCO prior to approving an exception for member-directed services.
    - For individuals receiving HCBS CSW services, the CDDO serves the child's current county of residence notifies KDADS if, upon investigation, it is determined agency-directed services are not available in the geographic area where the child is currently placed. The CDDO also notifies the home county CDDO (i.e. county where the CINC case originated and is assigned as the primary organization in KAMIS). The CDDO servicing the child currently shall notify KDADS and the home county CDDO the same day the determination is made that agency-directed services are not available.
    - Within two business days of receipt of notification, KDADS provides a written exception allowing member direction pursuant to section D of this policy to both the residence and home county CDDOs, including established timelines for review and renewal of the exception.
    - The child's Targeted Case Manager (TCM) works in coordination with DCF and the child placing agency to develop a POC that includes member direction.
    - The residential county CDDO works with the child's MCO to develop
    - agency-directed capacity.
    - The residential county CDDO arranges for transfer to an agency-directed provider as soon as capacity is created and, in turn, notifies the home county CDDO, KDADS, the
    - Permanency Program Administrator at DCF, and the child's MCO.
- Approved exceptions for member-directed services may continue as long as there is a documented, identified need. Upon approval of an exception, KDADS will arrange with DCF mutually agreed upon timelines for regularly scheduled review to determine if continuation of an approved exception is warranted.

Member Direction for Individuals in DCF Custody continued:

- Members or other responsible individuals are informed by the member's TCM that when choosing member direction (self-direction) of services, they must exercise responsibility for making choices about Personal Care Services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Members are provided with, at a minimum, the following information about the option to self-direct services:
  - The limitation to Personal Care Services in accordance with the respective HCBS waiver.
  - The need to enter into an agreement with the enrolled Financial Management Services (FMS) provider.
    Note: Minor children receiving the exception for member-directed services will not be the employer of record and therefore will not be issued a Federal Employer Identification Number (FEIN). In these cases, the foster care provider contracted by agreement with DCF shall assume all employer-related functions and be considered the employer of record for any workers hired to provide HCBS waiver services for the minor child.
  - The related responsibilities (outlined in I-D).
  - The potential liabilities related to the nonfulfillment of responsibilities in member direction.
  - The supports provided by the MCO and the TCM they have selected.
  - The requirements of Personal Care Service providers.
  - The ability of the member to choose not to participate in member-direct services at any time.
  - Other situations when the TCM may discontinue the member-direct option and recommend agency-directed services.
- The TCM is responsible for sharing information with the member about member direction of services. For CSW members, service providers are required to be affiliated with the CDDO providing services to the member. The CDDO providing services to the member is also responsible for completion of the Service Provider Choice Form and providing a completed copy of the form to the home county CDDO and the assigned MCO. The TCM is responsible for sharing more detailed information with the member about member direction of services once the member has chosen this option and identified an enrolled provider. This information is also available from the HCBS Program Manager and KDADS Regional Field Staff.
- Information regarding member-directed services is initially provided by the TCM during the POC/service plan process. During this process, the Member Choice form is completed indicating that the member has chosen HCBS services. The form is signed by the member and included in the POC. This information is reviewed at least annually with the member. The option to end member direction can be discussed, and the decision to change to agency-directed services can be made once an agency-directed provider is located.
  - Exceptions Concerning the Number of Nonrelated Individuals in DCF Custody Placed in the Same Licensed Foster Home
    Note: The statutes and regulations as quoted still reference KDHE as the licensing entity. However, DCF is, in practice, currently responsible for licensing functions.

Member Direction for Individuals in DCF Custody continued:

- The KDADS HCBS Program Manager shall review documentation including, but not limited to, the member's POC to determine if placement of the HCBS waiver member in the setting with more than two unrelated children is suitable in meeting the needs of all members. The KDADS HCBS Program Manager shall follow through with providing DCF a documented approval or denial of the exception request.
- Exceptions to the number of individuals that may be placed in the same licensed family foster home is governed by K.A.R. 28-4-804 as administered by KDHE with the cooperation of the DCF. *(Authorized by K.S.A. 65-508 (c) (1); implementing K.S.A. 65-504 and 65-508; effective March 28, 2008)*
- Each licensee who intends to change the terms of the license, including the maximum number or the age of individuals served, shall submit a request for an amendment on a form supplied by KDHE.
- Any applicant or licensee may request an exception from the Secretary of KDHE. Any request for an exception may be granted if the Secretary determines the exception is in the best interest of a child in foster care and the exception does not violate statutory requirements.
- Written notice from the Secretary stating the nature of the exception and its duration shall be kept on file in the family foster home and shall be readily accessible to KDHE, the child placing agent, the sponsoring child placing agency, DCF, the MCO, and the Kansas Juvenile Services Division of the Kansas Department of Corrections.

Documentation

- Written notification from KDADS to the MCO indicating an approved exception to allow member-directed services for the child in foster care.
- Written notification from KDADS to DCF indicating approval or denial of the exception allowing placement of a waiver member in a foster care setting with two or more unrelated individuals.

ANNUAL SPENDING CAP

The CSW includes an annual individual service budget limit of $20,000 per participant per plan year.

- Tracking:
  - MCOSs are responsible for managing service authorizations and payments such that the $20,000 per participant per plan year cap is not exceeded.
  - MCOs shall provide KDADS summary reports of individual utilization on a monthly basis for all members that have received services in excess of 65% of the participant's total budget amount within the participant's plan year.
  - MCOs must ensure that each participant's service authorizations and paid claims must reconcile to ensure total expenditures do no exceed $20,000 in waiver services costs per plan year.
  - There are no benefit limits specified for individual services under the CSW; however, participants may not exceed the $20,000 annual CSW cap.
  - MCOs and TCMs must establish service utilization monitoring systems that identify substantial deviations from planned service delivery.

ADMINISTRATIVE SERVICES

Financial Management Services

- A single statewide vendor will be contracted with to perform the FMS functions for the CSW.
- These functions are administrative in nature and excluded from the annual participant service cap.
- Although FMS will not be a waiver service, in order for Self-Directed claims to process, the FMS vendor will need to enroll in KMAP under Provider Type 55 and Specialty 530.
- KDADS will reimburse the FMS vendor on a per-member-per-month (PMPM) basis. Payment will be validated using visit activity recorded in the EVV system and reconciled against vendor invoices. Payment will be processed through KMMS using a non-managed care claims route similar to existing fee-for-service processing. These payments will be automatically generated through the EVV system and submitted to KMMS for adjudication and payment.
- For self-directed services or services with budget authority, the MCO must create an administrative authorization (T2040 U3) for the FMS vendor. This authorization enables the vendor to generate the required monthly visit record in the EVV system and allows AuthentiCare to generate the corresponding claims for KMMS processing.
    - FMS administrative claims will be submitted through AuthentiCare and processed through KMMS/Gainwell for adjudication and payment. Paid claims will be subject to post-payment review by KDADS to validate that the participant received a qualifying waiver service requiring FMS assistance during the month billed or the immediately preceding month. If no qualifying waiver services are received for two consecutive months, FMS administrative billing must cease until qualifying services resume.

Targeted Case Management (TCM) Role in Self-Directed Services

In addition to standard TCM functions, for participants who are self-directing, TCMs must also provide individualized assistance to help participants understand and manage self-directed CSW services within their approved budget. Key functions include:

- Helping participants and families translate the approved PCSP into a spending plan consistent with waiver requirements;
- Providing education and support on self-direction rights, responsibilities, and processes; and
- Offering guidance and coordination support to resolve service or staffing issues.

Refer to the Targeted Case Management – Intellectual/Developmentally Disabilities Provider Manual for additional information.

Financial Management Service Role

The FMS manages fiscal and employment-related functions for participants who self-direct their services. Core responsibilities include:

- Processing payroll and employment-related taxes for participant-hired workers;
- Maintaining required insurance and employment records;
- Ensuring compliance with EVV compliance requirements; and
- Providing budget and utilization reports to KDADS, MCOs, and participants as defined by contract.

PERSON CENTERED PLANNING (PCSP)

- Functional Assessment:
  - The CDDO completes the MFEI-I/DD within the required timeframes.
  - The MFEI-I/DD continues to serve as the instrument used for Level of Care (LOC) determination and waiver eligibility.
- Notification and Referral:
  - The MCO shall initiate the assessment process, and if the person indicates they plan to self-direct, shall refer the participant to the statewide FMS vendor upon completion of the assessment.
- Person Centered Planning and Spending Plan Development:
  - The TCM convenes the person-centered service-planning meeting with the participant and others chosen by the participant. During this meeting, the TCM:
    - facilitates discussion of goals, preferences, risks, and needed supports;
    - develops the service categories within the individualized budget expectation provided by the MCO into the PCSP; and
    - documents the participant's chosen services and supports consistent with assessed need.
  - As part of PCSP development, the TCM, for self-directed participants, helps the participant translate their services into an annual spending plan that:
    - reflects services and supports based on assessed need;
    - allocates dollars across authorized categories;
    - identifies worker wages within state-established rate bands;
    - accounts for EVV requirements;
    - remains within both the individualized budget expectation and the annual cap.
  - The finalized spending plan is attached as an addendum to the PCSP.
  - The TCM submits the completed PCSP and Spending Plan to the MCO for review.
- MCO Review and Service Authorization:
  - Upon receipt of the PCSP and Spending Plan, the MCO shall verify that:
    - all proposed expenditures align with the person's assessed needs;
    - the Spending Plan stays within the individualized budget expectation and the annual cap;
    - all selected worker wages fall within state-established rate bands; and
    - EVV requirements are correctly applied.
  - The MCO shall issue service authorizations within 7 calendar days of receiving a request for service as documented in the complete person-centered service plan.
- Ongoing Oversight:
  - The TCM shall support the participant in monitoring goal progress, service utilization, addressing risks, and coordinating PCSP updates.
  - The MCO shall conduct utilization review to ensure services delivered remain consistent with assessed need and authorized service categories.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUAL OR AGENCIES PROVIDING CSW SERVICES

- Services are provided according to the POC/Person-Centered Service Plan (PCSP), in a quality manner, and as authorized on the NOA.
- Provision of services is coordinated in a cost-effective and quality manner.
- Participant's independence and health are maintained, where possible, in a safe and dignified manner.
- Participant's concerns and needs, such as changes in health status, are communicated to the TCM and MCO care coordinator within 48 hours, including any ongoing reporting as required by the Medicaid program.
- Any failure or inability to provide services as scheduled in accordance with the POC/PCSP must be reported immediately, but at least within 48 hours, to the TCM and MCO care coordinator.

HIPAA COMPLIANCE

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

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

7000. BILLING INSTRUCTIONS

INTRODUCTION TO THE CMS-1500 CLAIM FORM

Providers must use the CMS-1500 paper or equivalent electronic claim form when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

An example of the CMS-1500 Claim Form and instructions are available on the KMAP public and secure portals under the Claims (Sample Forms and Instructions) heading on the Forms page of Provider Publications.

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

- Sending a KanCare paper claim to KMAP
- A CMS-1500 Claim Form carbon copy
- Using a PO Box in the service location field

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

Submission of Claim

Send completed claim and any necessary Attachments to:

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

All claims for the following self-directed services must be submitted through the EV&M system, AuthentiCare Kansas web application.

- Respite Care
- Personal Care Services
- Financial Management Services

7010. SPECIFIC BILLING INFORMATION

Enter the following procedure code with modifier for applicable services in field 24D of the CMS-1500 Claim Form or equivalent X12 837P transaction.

Service	Agency-Directed	Self-Directed	Unit Definition
Assistive Technology Consultation	97755-U8	–	One unit equals 15 minutes.
Assistive Technology Install/Equipment	T1998-U8	–	One unit equals one purchase.
Assistive Technology Training	97535-U8	–	One unit equals 15 minutes.
Behavior Therapy	H0004-U8	–	One unit equals 15 minutes.
Benefits Planning	T2019-U8	–	One unit equals 15 minutes.
Career Exploration and Planning, Group	H2023-U3	–	One unit equals 15 minutes.
Career Exploration and Planning, Individual	H2023-U1	–	One unit equals 15 minutes.
Family/Caregiver Support and Training, Group	S5110-U1	S5110-U3	One unit equals 15 minutes.
Family/Caregiver Support and Training, Individual	S5110-U8	S5110-U2	One unit equals 15 minutes.
Financial Management Services (FMS)	–	T2040-U3	One unit equals 15 minutes.
Home and Environment Modification Services	S5165-U8	–	One unit equals one purchase.
Home Telehealth Installation	S0315-U8	–	One unit equals one installation.
Home Telehealth Monthly	S0317-U8	–	One unit equals one day.
Individual Directed Goods and Services	–	T2028-U8	One unit equals one purchase.
Individual Employment Support, Initial	H2023-U8	–	One unit equals 15 minutes.
Individual Employment Support, Maintenance	H2025-U8	–	One unit equals 15 minutes.
Individual Employment Support, On-going	H2025-U3	–	One unit equals 15 minutes.
Life Skills Support, Group	H2014-U8	–	One unit equals 15 minutes.
Life Skills Support, Individual	H2014-U3	–	One unit equals 15 minutes.
Medication Reminder Call	S5185-U8	–	One unit equals one month.
Medication Reminder Dispenser	T1505-U8	–	One unit equals one month.
Medication Reminder Installation	T1505-U3	–	One unit equals one installation.
NMT, Group 2-3	A0080-U3	A0080-U9	One unit equals one mile or public fare.
NMT, Group 2-3, Modified	A0130-U3	A0130-U9	One unit equals one mile or public fare.
NMT, Group 4+	A0080-U8	A0080-UA	One unit equals one mile or public fare.
NMT, Group 4+, Modified	A0130-U8	A0130-UA	One unit equals one mile or public fare.
NMT, Single (public or private bus, intra or inter-state carrier)	A0110-U8	A0110-U6	One unit equals one trip.
NMT, Single (public or private bus, intra or inter-state carrier)	T2004-U8	T2004-U6	One unit equals one trip.
NMT, Single, Modified	A0130-U1	A0130-U6	One unit equals one mile or public fare.
Non-Medical Transportation (NMT), Single	A0080-U1	A0080-U6	One unit equals one mile.
Occupational Therapy	G0152-U8	–	One unit equals 15 minutes.
Personal Care Services	S5125-U8	T1019-U8	One unit equals 15 minutes.
Personal Emergency Response Services, Installation	S5160-U8	–	One unit equals one installation.
Personal Emergency Response Services, Rental	S5161-U8	–	One unit equals one month.

Service	Agency-Directed	Self-Directed	Unit Definition
Physical Therapy	G0151-U8	–	One unit equals 15 minutes.
Remote Support. Each additional 20 minutes	99458-U8	–	One unit equals 20 minutes.
Remote Support. First 20 minutes	99457-U8	–	One unit equals 20 minutes.
Respite Care, Group	T1005-U2	T1005-U8	One unit equals 15 minutes.
Respite Care, Individual	T1005-U1	T1005-U3	One unit equals 15 minutes.
Specialized Medical Equipment and Services	T2029-U8	–	One unit equals one purchase.
Speech and Language Therapy	G0153-U8	–	One unit equals 15 minutes.
Vehicle Modification Services	T2039-U8	–	One unit equals one purchase.

Client Obligation
If client obligation has been assigned to a particular provider and this provider has been informed that he or she is to collect this portion of the cost of service from the client, the provider should not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Third-Party Liability
KMAP is **secondary payor** to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Services for Children and Youth with Special Health Care Needs (CYSHCN) program
- DCF Rehabilitation Services
- Indian Health Services
- Crime Victim's Compensation Fund

KMAP is primary to the four programs noted above. Refer to the *General TPL Payment Provider Manual* for further guidance on the KMAP public or secure websites.

One Plan of Care per Month
Prior authorizations through the POC process are approved for one month only. Dates of service (DOS) that span two months must be billed on two separate claims.

Example: Services for July 28-August 3 must be billed with July 28-31 on one claim and August 1-3 on a second claim.

Overlapping Dates of Service
The dates of service on the claim must match the dates approved on the POC and cannot overlap. For example, there are two lines on the POC with the following dates of service, July 1 – 15 and July 16 – 31. If billing service dates of July 8 – 16, the claim would deny because the billed dates cross POC segments. For the first service line, any date that falls between July 1 and July 15 will prevent the claim from denying for date of service.

Same Day Service
For certain situations, HCBS CSW program services approved on a POC and provided the same time a member is hospitalized or in a nursing facility may be allowed. Situations are limited to:

- Services provided the date of admission, if provided prior to admission
- Services provided the date of discharge, if provided following discharge

7020. FINAL RULE MONITORING AND COMPLAINCE

Providers delivering Home and Community-Based Services (HCBS), including Community Support Waiver (CSW) services, must comply with applicable HCBS Settings Final Rule requirements under 42 C.F.R. § 441.301(c). These requirements are intended to ensure that services are delivered in settings that support individual rights, choice, privacy, dignity, autonomy, independence, and access to the broader community.

Compliance with Electronic Visit Verification (EVV), authorization, and claims submission requirements does not replace a provider's responsibility to comply with the HCBS Settings Final Rule, applicable waiver assurances, provider qualifications, service standards, or other program requirements.

Applicability to CSW Providers and Services
HCBS Settings Final Rule requirements apply to providers delivering services under an approved Kansas 1915(c) HCBS waiver, including providers delivering CSW services. Depending on the service delivery model and setting, a provider or service may be subject to:

- HCBS Compliance Portal registration;
- Presumed Compliance screening;
- Community-Based Support screening;
- HCBS Readiness Assessment;
- Heightened Scrutiny review;
- Recertification or reconfirmation requirements; or
- Other monitoring activities established by the Kansas Department for Aging and Disability Services (KDADS).

Provider-Owned, Managed, or Controlled Settings
Provider-owned, provider-managed, or provider-controlled settings must deliver services according to each participant's assessed needs and person-centered service plan. Such settings must support integration into the broader community, individual choice of setting and services, privacy, dignity, respect, independence, control over daily activities, access to food and visitors, and physical accessibility.

Any modification of an HCBS Settings Final Rule requirement must be based on a specific assessed need and documented in the participant's person-centered service plan. The documentation must include the interventions attempted, less intrusive alternatives considered, the scope and duration of the modification, ongoing data review, periodic review requirements, the participant's informed written consent, and assurance that the intervention will not cause harm.

Presumed Compliance and Community-Based Services
A provider or service that is not classified as provider-owned, provider-managed, or provider-controlled may qualify for presumed compliance or may be evaluated as a community-based support service. Qualification is based on the applicable service, setting, and method of service delivery.

Providers must complete the screening or assessment required by KDADS for each applicable service. A provider that meets the established criteria will receive the corresponding compliance certificate. A provider that does not meet presumed compliance criteria may be required to complete an additional community-based, non-residential, or residential assessment.

The applicable compliance process is determined by the service provided, the service delivery method, and whether the setting is provider-owned, provider-managed, provider-controlled, community-based, or otherwise eligible for presumed compliance.

Compliance Requirements for Providers:
The Final Rule's ongoing monitoring and compliance will be assessed based on the following billing codes:

S5101	S5102	S5125-UA	T2016	T2021

New providers enrolling with KMAP to render services under any of the service codes above and further identified under the provider types and specialties listed below, will need to present verification of HCBS Compliance Portal registration prior to completing the enrollment process.

Provider Type	Provider Specialty	Billing Codes Captured	Waiver Service
55	363	S5125	Personal Care Services (BI)
55	364	T2016	Residential Supports (I/DD)
55	365	S5125	Personal Care Services (I/DD)
55	511	S5125	Personal Care Services (FE)
55	367	S5125 S5160, S5161 T2025	Personal Care Services (PD) Personal Emergency Response System (PD) Enhanced Care Services (PD)
55	410	S5101, S5102	Adult Day Care (FE)
55	510	S5125 S5130	Personal Care Services (FE) Personal Care Services Level 1 (FE)
55	511	S5125 S5125-UA	Personal Care Services Level II and III (FE)
55	520	T2021	Day Supports (I/DD)
55	570	S5110-U1, S5110-U8	Family/Caregiver Support and Training (CSW)
55	571	S5110-U1, S5110-U8	Family/Caregiver Support and Training (CSW)
55	572	S5110-U1, S5110-U8	Family/Caregiver Support and Training (CSW)
55	573	S5110-U1, S5110-U8	Family/Caregiver Support and Training (CSW)
55	578	99457-U8, 99458-U8	Remote Supports (CSW)
55	581	H2023-U1, H2023-U3 H2023-U8, H2025-U3, H2025-U8	Career Exploration and Planning (CSW) Individual Employment Support (CSW)
55	582	H2014-U3, H2014-U8	Life Skill Services (CSW)
55	583	H2014-U3, H2014-U8	Life Skill Services (CSW)
55	584	S5125-U8	Personal Care Services (CSW)

Providers will be required to obtain annual certification from the Kansas Department for Aging and Disability Services (KDADS) for each setting where the above codes are billed.

HCBS Compliance Portal Registration
The Kansas HCBS Compliance Portal is the designated system of record for HCBS settings compliance activities. Providers subject to registration must obtain and maintain the required registration verification, screening outcome, certification, or attestation.

Providers enrolling with KMAP for an applicable provider type, provider specialty, and service must present verification of HCBS Compliance Portal registration before completing enrollment.

A provider operating a licensed service without an existing service delivery setting must provide proof of HCBS Compliance Portal registration to the applicable licensing entity. A provider operating a licensed service with an existing service delivery setting must provide the required HCBS compliance certification for each setting.

Provider Responsibilities
CSW providers must:

- Maintain all required HCBS Compliance Portal registrations, certificates, attestations, screenings, and assessments;
- Ensure each service is delivered according to the participant's PCSP and authorization;
- Maintain compliance with individual rights, choice, privacy, dignity, autonomy, independence, and community integration requirements;
- Notify the appropriate entity when a change in service delivery or setting may affect the provider's compliance status;
- Keep supporting policies, procedures, manuals, training records, and compliance evidence current;
- Make applicable records and documentation available when requested for monitoring or oversight;
- Complete required remediation when an area of noncompliance is identified;
- Meet all EVV, AuthentiCare, authorization, documentation, provider enrollment, and claims submission requirements; and
- Maintain documentation demonstrating that services were delivered in accordance with applicable federal and state requirements.

The documents and evidence submitted through the HCBS Compliance Portal must be current and up to date. KDADS may request access to documentation and interviews to verify continued compliance.

Training Requirements
Providers delivering CSW services must ensure that staff and recurrent volunteers receive required HCBS Settings Final Rule training annually and as otherwise needed. New staff and recurrent volunteers must receive the required training within three months of their start date.

Provider staff must complete the required competency assessment, and providers must retain the applicable completion and training records. Training records must be maintained for five years and made available to the KDADS Settings Final Rule Monitoring Team upon request. These training requirements apply to CSW providers, including Community Service Providers, Employment Support Agencies, Centers for Independent Living, Community Mental Health Centers, peer providers, and Financial Management Service entities.

For participant-directed CSW services, Targeted Case Managers are responsible for ensuring that workers employed or engaged by participants are informed of and have access to the required HCBS Settings Final Rule training.

Ongoing Monitoring and Recertification
Providers must participate in ongoing compliance monitoring and complete the screening, assessment, recertification, or reconfirmation process applicable to the service and setting.

KDADS requires applicable presumed compliant and community-based services to undergo screening every 365 days and when there is a change in service delivery. Provider-owned, provider-managed, or provider-controlled settings must reconfirm every 365 days that no changes have occurred to the setting or its immediate surroundings. Changes may require an additional HCBS Readiness Assessment.

KDADS may conduct onsite monitoring regularly, as needed, or in response to a complaint or concern. Settings may be examined at any time, and KDADS may request records, documentation, and interviews to verify continued compliance.

Compliance Documentation
Providers must retain current documentation supporting compliance, including, as applicable:

- HCBS Compliance Portal registration verification;
- HCBS Compliance Certificate;
- Presumed Compliance Certificate;
- Community-Based Support Compliance Certificate;
- Signed Heightened Scrutiny Attestation;
- HCBS Readiness Assessment documentation;
- Person-centered service plans and supporting documentation;
- Policies, procedures, manuals, and handbooks;
- Staff and recurrent volunteer training records;
- Remediation plans and supporting evidence; and
- Documentation of changes to the service delivery method, setting, or immediate surroundings.

MCOs must verify setting compliance as part of the HCBS provider qualification audit. Acceptable documentation identified by the policy includes a current HCBS Compliance Certificate or a signed Heightened Scrutiny Attestation.

Reporting Potential Violations
HCBS participants, legal representatives, guardians, providers, care coordinators, Targeted Case Managers, Community Developmental Disability Organizations, and other interested parties may report potential HCBS Settings Final Rule violations to KDADS.

Reports may be submitted to the KDADS Settings Rule Administrator by telephone at 785-296-4986 or by email at KDADS.FinalRule@ks.gov. KDADS will track and follow up on reported concerns.

Non-Compliance:

- KDADS will notify the MCO and provider when becoming aware of a non-compliant setting by issuing a corrective action plan (CAP) and indicating a date for the provider/setting to achieve compliance.
- In the event compliance is not achieved by the date set in the CAP, and an HCBS member is active and receiving services from the identified setting, a transition process must be immediately initiated following the KDADS HCBS Transition Policy:
    - Notification will be made by KDADS to the provider, MCO, and KMAP and will include a date that payment for services will no longer be authorized for the member(s) receiving services in the non-compliant setting.
    - KDADS, with the assistance of KDHE, may request a post-payment review and recoup funds from the provider in the event transitions do not occur from non-compliant settings.

Recertification Criteria:

1. Providers offering services that are not categorized as provider owned, managed, and/or controlled, which may be presumed to be compliant with the Settings Final Rule, shall undergo the presumed compliant screening every 365 days for each service presumed to be compliant.
    a. The provider shall recertify in the event there is a change in service delivery.
    b. A certificate showing the service delivery method is compliant shall be issued.
2. Providers of settings classified as provider owned, managed, and/or controlled, shall complete the HCBS Readiness Assessment for Residential/Day Services, and
    a. Shall re-confirm that no changes have been made to the settings or its immediate surroundings every 365 days after the setting was issued compliance status.
    b. A certificate showing the setting is compliant shall be issued.
    c. If there have been changes to the setting or its immediate surroundings, then the changes may require the setting to complete a new HCBS Readiness Assessment for Residential/Day Services.

Any questions can be directed to KDADS.FINALRULE@ks.gov.

Relationship to EVV and AuthentiCare

HCBS Settings Final Rule compliance and EVV compliance are separate but concurrent provider responsibilities.

AuthentiCare is the approved claims entry point for services designated as requiring EVV. Providers must comply with applicable AuthentiCare visit documentation, authorization, exception resolution, attestation, and claims submission requirements. A visit recorded or confirmed in AuthentiCare does not, by itself, establish that the provider or setting complies with the HCBS Settings Final Rule.

Similarly, an HCBS compliance certificate, Presumed Compliance Certificate, Community-Based Support Compliance Certificate, or Heightened Scrutiny Attestation does not replace:

- EVV check-in and check-out requirements;
- Service authorization requirements;
- Procedure code and modifier requirements;
- Provider type and specialty requirements;
- Documentation of services delivered;
- Claims submission requirements; or
- Other service-specific coverage and billing requirements.

Relationship to EVV and AuthentiCare continued
Providers must satisfy both the applicable EVV requirements and the applicable HCBS settings compliance requirements.

CSW Service Delivery Requirements
CSW services must be delivered in accordance with the participant's Person-Centered Service Plan (PCSP), applicable authorization, approved service definition, and provider qualification requirements.

For services requiring EVV, providers must ensure that the visit information entered or transmitted to AuthentiCare accurately reflects the service delivered. The procedure code, modifier, units, service date, service location, provider information, and other required visit or claim information must correspond to the applicable authorization and service documentation.

For optional EVV services, providers may use AuthentiCare when permitted, but must continue to comply with all applicable authorization, service documentation, provider qualification, HCBS settings, and claims submission requirements.

Classification of a service as required or optional for EVV does not determine whether the service or setting qualifies for presumed compliance or another HCBS settings review pathway.

7030. QUALITY ASSURANCE

HCBS Quality Assurance
Effective August 1, 2024, HCBS Quality Assurance (QA) Policy provides quality assurance oversight for Medicaid 1915(c) HCBS in the State of Kansas. This policy serves as a basis for the State's QA Unit's review of the HCBS Waiver Programs based on HCBS Performance Measures, Program Policies, and Waiver Requirements per waiver type.

Quality Reviews:
KDADS shall conduct quality reviews on Level of Care (LOC) assessments and MCO records for members receiving HCBS Programs to determine:

- KanCare Quality Performance Measure Outcomes
  - The Performance Measures are included in all current/approved HCBS waivers.
- KDADS HCBS Waiver Program Requirement Outcomes
  - May include, but are not limited to, State Plan requirements and HCBS waiver requirements.

As a condition of Centers for Medicaid and Medicare Services (CMS) waiver approval of each HCBS waiver program, the State of Kansas shall have and comply with defined and approved Quality Assurance (QA) policies and procedures contained in this policy.

- The following sub-assurances of the State's HCBS waiver shall have defined and approved QA requirements:
  - Administrative Authority.
  - Evaluation/Reevaluation LOC.
  - Qualified Providers;
  - Service Plan;
  - Health and Welfare; and
  - Financial Accountability
    - KDADS shall conduct QA checks through staff designated as Quality Management Specialists (QMS).
    - KDADS may conduct QA checks through, but not limited to, any of the following methods and data sources:
      - LOC Assessor file reviews
      - MCO file reviews
      - Member's survey feedback
      - Provider's Credentialing, Training, and Background Checks
      - Data found in the following systems:
        - Kansas Aging Management Information System (KAMIS)
        - KMMS
        - Medicaid Management Information System (MMIS)
        - Quality Review Tracker (QRT)
        - Kansas Adverse Incident Reporting and Management System (AIRS)

Quality Assurance Procedures

A. KDADS Financial and Information Services Commission (FISC) will select and assign a representative sample of HCBS waiver members' case files to the QMS Unit for quarterly review.
B. Documentation Required.
    1. Documentation required for each waiver can be found in the **Documentation** section of this bulletin.
C. Authorized Signature
    1. Signatures must be original handwritten, including digital signatures, and dated by the recipient and/or their representative.
        a) A signature on file and/or a signature that converts to a "typed" signature is unacceptable.
        b) If a recipient has a legal guardian, representative, or activated durable power of attorney (DPOA), the legal guardian or DPOA must sign all required document(s).
            i. In the event of representation through a DPOA, supporting documentation showing DPOA activation is required.
            ii. If an electronic signature is used, it must comply with the KDHE KMAP Provider Bulletin Number 782: Electronic Documentation. This policy must be documented to the KDADS HCBS Director, Policy Program Oversight Manager, and QA Manager.
    2. In the event a member is unable to manually/hand sign their own name due to physical or other limitations, one or more of the following methods may be utilized:
        a) The use of a distinct mark representing the member's signature;
        b) The use of the member's signature stamp and/or;
        c) The use of an identified designated signatory.
    3. If a member utilizes any of the three options in **Quality Assurance Procedures C.2** listed above, documentation supporting the method selected must be uploaded with the QA review.
    4. Each "authorized signature" must be dated.
D. Procedure for conducting quality reviews shall be as follows:
    1. File Reviews:
        a) KDADS shall review documentation uploaded in the Quality Review Tracker (QRT) by the MCOs and/or assessing entities using the established KDADs protocols.
            i. KDADS QMS shall record findings from file reviews in the QRT for the MCO's/assessor's remediation.
E. Record Submission
    1. MCO files are to be uploaded to the QRT database.
    2. LOC assessing entity must upload documents for all HCBS waivers.
        a) LOC Assessment documentation for all HCBS waivers, unless an exception is granted for a specific waiver, may be found in the KAMIS or QRT.
    3. Case file documentation must be:
        a) Properly labeled with document name and the completion date (month and year); and
        b) Documentation must be legible.
    4. At the beginning of each upload period, KDADS will send out specific information regarding documentation that must be uploaded for the audit.
    5. When documentation is uploaded to QRT, the MCO/assessing entity must mark the upload as "complete."
    6. Documentation uploaded after the deadline will not be considered for the quality review.

Quality Assurance Procedures continued

F. Deadline for Record Submission
   1. Case files for review shall be listed in the QRT for the review period.
      a) KDADS QA Manager shall notify the MCOs and assessing entity of the required upload.
      b) MCOs and the assessing entity shall have 15 calendar days from upload notification to upload the required documentation.

G. An example of the timeline for a Quality Review is outlined in the following chart:

Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessing Entity Samples Posted	MCO/Assessing Entity Upload Period (*15 days)	Review of Data (*60 days)
01/01 – 03/31	04/01 – 04/15	04/16	04/16 – 04/30	05/01 – 07-01
04/01 – 06/30	07/01 – 07/15	07/16	07/16 – 07/31	08/01 – 10/01
07/01 – 09/30	10/01 – 10/15	10/16	10/16 – 10/31	11/01 – 01/01
10/01 – 12/31	01/01 – 01/15	01/16	01/16 – 01/31	02/01 – 04/01

H. Findings and Remediation
   1. Protocol Scoring Options:
      a) "Compliant" documentation is provided and meets compliance requirements.
      b) "Non-compliant" documentation was not provided or was not correct or complete.
         i. Missing Document (Document/documentation not provided for review);
         ii. No Valid Signature and/or Date ("Valid signature" means by the individual and/or representative/guardian or Care Coordinator/Case Manager. Must have both signature and date);
         iii. Incomplete (Form was not completed in its entirety);
         iv. Inaccurate (Scoring or eligibility is not correct, or services listed are not being received as outlined in the PCSP, or the process for developing a PCSP was not followed); or
         v. Timeline not met.
      c) "N/A" when not applicable to the protocol question.
   2. Findings from file reviews will be recorded in QRT.

I. Remediation and Response Process
   1. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
   2. CMS requires states to submit remediation language and a Quality Improvement Plan for any HCBS Performance Measure when the statewide average for a waiver is less than 86%. Therefore, KDADS shall complete data analysis to ensure that each quality assurance or sub-assurance of less than 86% is remediated. Further, CMS also requires the state to remediate any "non-compliant internally" (less than 100%) for a performance measure even though it may not be below the 86% threshold requiring the data analysis:
      a) KDADS shall notify the MCO and assessing entity of quality assurance or sub-assurance below 86% with details of each finding.
      b) KDADS shall notify the provider of each non-compliance with a performance measure.

c) Upon notification of the remediation requirement for quality assurance sub-assurance, or performance measures, providers must respond within 10 business days with a detailed plan for correction/remediation strategies and a timeline for completion.
d) KDADS staff shall review the received remediation plan for approval. If a remediation plan is not approved, KDADS shall notify the provider and request that acceptable remediation be resubmitted.
e) Once a remediation plan is approved with a timeline for compliance, KDADS will monitor for compliance.

3. KDADS shall immediately forward/report Abuse, Neglect, or Exploitation (ANE) issues to the designated state reporting agency.
4. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
5. If QMS finds issues or concerns on a specific case during a review:
   a) The issues or concerns shall be entered in QRT.
   b) The QRT system will send an alert to the HCBS Program Manager for the Program Manager's review. Issues that may cause an alert to the HCBS Program Manager include, but are not limited to, the following:
      i. The member being served could not be located or no longer resides at the address provided in the case record;
      ii. Case should be reviewed for potential closure;
      iii. Assessment is not current;
      iv. Member being served stated they would like their Care Coordinator to contact them;
      v. There is a protective service concern;
      vi. Spouse cannot serve as a Personal Care Service Worker or in any other paid capacity without a "Spousal Exception;"
      vii. Activated DPOAs/legal guardians are not allowed to provide any direct services without court documentation approving them to do so;
      viii. The assessor is not on the qualified assessor list.

J. Quality reviews of credentialing; background checks; provider's training:
   1. Refer to policies posted on the KDADS website at HCBS Policies.
   2. Credentials such as provider specifications applicable to each HCBS waiver, background checks, and training are to be provided per the direction of KDADS.
   3. Provider qualification audit review process per the direction of KDADS and waiver standards.

Documentation:

A. Forms
   1. All forms and templates will be sent to the appropriate assessing entity or MCO at the beginning of the upload period via secure email. Specific required documentation for the audit will be listed in the following documents:
      a) HCBS LOC review: Required documentation for QA Reviews (Frail Elderly (FE), Physical Disability (PD), BI);
      b) HCBS LOC Review: Required Documentation for QA Reviews (Autism (AU));
      c) HCBS LOC Review: Required Documentation for QA Reviews (CSW);
      d) HCBS LOC Review: Required Documentation for QA Reviews (IDD);
      e) HCBS LOC Review: Required Documentation for QA Reviews (TA);
      f) HCBS LOC Review: Required Documentation for QA Reviews (Severe Emotional Disability (SED)

Documentation continued:

g) HCBS MCO Record Review: Required Documentation for QA Reviews (Except SED);
h) HCBS MCO LOC and Record Review: Required Documentation for SED QA Reviews;
i) QMS' official case review record and findings are in QRT.

2. Required documentation is subject to change and will be updated on the specific record review document sent out via email at the beginning of every upload period.
3. For the required documentation, assessing entities/MCOs must provide all current and prior documentation that demonstrates compliance with CFR Regulations, performance measures, applicable policies, and program mandates for every day of the review period.

B. LOC Performance Measure Documentation
1. The LOC assessing entity is responsible for providing appropriate documentation for this section of the audit review.
2. Requests for LOC documentation may include, but is not limited to:
a) Specific waiver eligibility assessment, applicable re-assessments, and any medical documentation if required for eligibility;
b) Initial Intake/Referral Form;
c) 3160 approval/Functional Eligibility Assessment request from the specific waiver program manager – if coming off a waitlist or is a crisis/exception, when the initial assessment has expired and will need a new assessment to be eligible for the waiver.

C. Service Plan and Health and Welfare Performance Measure Documentation
1. The MCOs are responsible for providing the appropriate documentation for this section of the audit review.
2. Requests for Service Plan and Health and Welfare Documentation may include, but are not limited to:
a) 3160 and 3161 – include the initial notification from the eligibility worker of a new member;
b) PCSP for current and prior PCSP to determine timeliness. The following is considered part of the individual's PCSP and is subject to review:
i. Documentation of member choice, as directed by the waiver;
ii. Physical, Functional, and Behavioral Assessment;
iii. Back up plan;
iv. Evidence of information provided on reporting suspected abuse, neglect, and exploitation; and
v. Goals
c) Physician/RN Statement (if applicable);
d) Legal representative, DPOA, and/or guardianship paperwork
e) Physical exam;
f) Evidence of rights and responsibilities discussed with member and/or representative/guardian;
g) Evidence of appeal and grievance rights/processes discussed with member and/or representative/guardian;
h) Notice of Actions (for any updates or changes in Service Plans, including annual reviews and/or adverse actions);
i) Log or case notes (inclusive of verification of services being received in the type, scope, amount, duration, and frequency specified in the Service Plan);

7040. ADVERSE INCIDENT REPORTING MANAGEMENT

Adverse Incident Reporting & Management

The AIR system is designed for KDADS service providers and contractors to report all adverse incidents and serious occurrences involving individuals receiving services from KDADS. Providers can access the AIR system from the KDADS Home page under the **Quick Links** heading.

General Requirements

A. All HCBS providers shall make adverse incident reports in accordance with this policy as set forth herein.
B. All adverse incidents including those required to be reported to the Department of Children and Families (DCF), shall be reported to KDADS by direct entry into the KDADS web-based AIR system no later than 24 hours after becoming aware of the adverse incident.
C. Incidents shall be classified as adverse incidents when the event brings harm or creates the potential for imminent serious harm to any individual eligible to receive services from an HCBS waiver provider at the time of the occurrence.
D. A report shall be made into the AIR system for any adverse incident regardless of the location where it occurred. Location includes, but is not limited to, any premises owned or operated by a provider or facility licensed by KDADS; operating under the Older Americans Act or the Senior Care Act; or operating under the Money Follows the Person program or the Behavioral Health Services programs.
E. KDADS Program Integrity and Compliance (PIC) shall offer AIR system training to MCO staff, and all interested and involved parties.
F. Training materials shall be provided on site and on the KDADS website – www.kdads.gov.
G. Reporting of All Other Adverse Incidents:
    a. The reporting of all other adverse incidents, as defined in this policy, not required via K.S.A. 39-1433, K.S.A.38-2223, shall be made through the AIR system.

7050. ELECTRONIC VISIT VERIFICATION (EVV)

AuthentiCare is the approved claims entry point for services that are subject to mandatory Electronic Visit Verification (EVV). Initial claims for services requiring EVV that are not submitted through AuthentiCare will be denied.

Claims for required EVV services will be generated in AuthentiCare using authorization, provider, caregiver visit, and provider-entered information. This requirement excludes WORK and STEPS services that are not processed through AuthentiCare.

Certain services are designated as optional EVV services. Providers may document and submit these services through AuthentiCare; however, use of EVV is not required for these services. Claims for optional EVV services are not subject to denial solely because the claim was not received from AuthentiCare.

Community Support Waiver Services – EVV

The following Community Support Waiver services are configured in AuthentiCare. All listed services require authorization. The EVV classification identifies whether the service must be documented through EVV or may be documented through EVV at the provider's option.

For time-based services, one unit equals 15 minutes. A maximum of 24 hours is allowed between check-in and check-out. Non-time-based services are associated with one unit per service event and do not have a check-in-to-check-out window.

Behavioral Therapy

- Behavioral Therapy must be billed using procedure code H0004 with modifier U8. The service is displayed in AuthentiCare as CSW – Behavioral Therapy.
- One unit equals 15 minutes. The authorization service period is 10 units bi-monthly, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 590, 591, 592, 593, 594, or 595. An ordering provider is not required on the EVV authorization.

Telemonitoring Installation

- Telemonitoring Installation must be billed using procedure code S0315 with modifier U8. The service is displayed in AuthentiCare as CSW – Telemonitoring Installation.
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is 16 units, one time. A checkout window does not apply. Authorization is required, ***but EVV participation is optional.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 587 or 588. An ordering provider is not required on the EVV authorization.

Home Telehealth Rental

- Home Telehealth Rental must be billed using procedure code S0317 with modifier U8. The service is displayed in AuthentiCare as CSW – Home Telehealth – Rental.
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is nine units monthly. A checkout window does not apply. Authorization is required, ***but EVV participation is optional.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 587 or 588. An ordering provider is not required on the EVV authorization.

Medication Reminder – Dispenser Installation

- Medication Reminder – Dispenser Installation must be billed using procedure code T1505 with modifier U3. The service is displayed in AuthentiCare as CSW – Medication Reminder – Dispenser Installation.
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is 16 units, one time. A checkout window does not apply. Authorization is required, ***but EVV participation is optional.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 589. An ordering provider is not required on the EVV authorization.

Medication Reminder – Dispenser

- Medication Reminder – Dispenser must be billed using procedure code T1505 with modifier U8. The service is displayed in AuthentiCare as CSW – Medication Reminder – Dispenser.
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is nine units monthly. A checkout window does not apply. Authorization is required, ***but EVV participation is optional.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 589. An ordering provider is not required on the EVV authorization.

Medication Reminder – Call/Alarm

- Medication Reminder – Call/Alarm must be billed using procedure code S5185 with modifier U8. The service is displayed in AuthentiCare as CSW – Medication Reminder – Call – Alarm.
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is nine units monthly. A checkout window does not apply. Authorization is required, ***but EVV participation is optional.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 589. An ordering provider is not required on the EVV authorization.

Occupational Therapy

- Occupational Therapy must be billed using procedure code G0152 with modifier U8. The service is displayed in AuthentiCare as CSW – Occupational Therapy.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 596 or 599. An ordering provider is not required on the EVV authorization.

Self-Directed Personal Care Services

- Self-Directed Personal Care Services, or PCS, must be billed using procedure code T1019 with modifier U8. The service is displayed in AuthentiCare as CSW – Self-Directed Personal Care Services (PCS).
- One unit equals 15 minutes. The authorization service period is nine units monthly, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 530. An ordering provider is not required on the EVV authorization.

Agency-Directed Personal Care Services

- Agency-Directed Personal Care Services, or PCS, must be billed using procedure code S5125 with modifier U8. The service is displayed in AuthentiCare as CSW – Agency-Directed Personal Care Services (PCS).
- One unit equals 15 minutes. The authorization service period is nine units monthly, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 584. An ordering provider is not required on the EVV authorization.

Physical Therapy

- Physical Therapy must be billed using procedure code G0151 with modifier U8. The service is displayed in AuthentiCare as CSW – Physical Therapy.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 597 or 599. An ordering provider is not required on the EVV authorization.

Agency-Directed Respite – Individual

- Agency-Directed Respite – Individual must be billed using procedure code T1005 with modifier U1. The service is displayed in AuthentiCare as CSW – Agency-Directed Respite – Individual.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 585 or 586. An ordering provider is not required on the EVV authorization.

Agency-Directed Respite – Group

- Agency-Directed Respite – Group must be billed using procedure code T1005 with modifier U2. The service is displayed in AuthentiCare as CSW – Agency-Directed Respite – Group.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 585 or 586. An ordering provider is not required on the EVV authorization.

Self-Directed Respite – Individual

- Self-Directed Respite – Individual must be billed using procedure code T1005 with modifier U3. The service is displayed in AuthentiCare as CSW – Self-Directed Respite – Individual.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 530. An ordering provider is not required on the EVV authorization.

Self-Directed Respite – Group

- Self-Directed Respite – Group must be billed using procedure code T1005 with modifier U8. The service is displayed in AuthentiCare as CSW – Self-Directed Respite – Group.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, **and EVV participation is mandatory.**
- Eligible providers must be enrolled under provider type 55 with provider specialty 530. An ordering provider is not required on the EVV authorization.

Speech and Language Therapy

- Speech and Language Therapy must be billed using procedure code G0153 with modifier U8. The service is displayed in AuthentiCare as CSW – Speech and Language Therapy.
- One unit equals 15 minutes. The authorization service period is 15 units annually, and the maximum checkout window is 24 hours. Authorization is required, ***and EVV participation is mandatory.***
- Eligible providers must be enrolled under provider type 55 with provider specialty 598 or 599. An ordering provider is not required on the EVV authorization.

Financial Management Services

- Financial Management Services, or FMS, must be billed using procedure code T2040 with modifier U3. The service is displayed in AuthentiCare as CSW – Financial Management Services (FMS).
- This is a non-time-based service. One unit is associated with each service event. The authorization service period is nine units monthly. A checkout window does not apply. An authorization is required, and the service is included in the required EVV service configuration.
- Eligible providers must be enrolled under provider type 55 with provider specialty 530. An ordering provider is not required on the EVV authorization.

Claims Process

- Claims will be created using the information that comes from MCO and Gainwell FFS (payer) authorizations, caregiver visits, and provider data entry.
- Negotiated rates, up to 12 diagnosis codes, and ordering provider NPI information will be on the claim for the services being provided based on data in the authorization file from payers.
- Providers will select the appropriate diagnosis pointers for each service line.
- Caregivers will populate the Place of service (POS) where care takes place when submitting visit information. This will be populated into the claim.
- The procedure code and modifier submitted on the claim must correspond to the authorized service and the service recorded in AuthentiCare.
- The units submitted must correspond to the applicable unit definition for the service.
- Time-based services must be documented using the applicable check-in and check-out information.
- Non-time-based services do not require check-in and check-out times unless otherwise directed by the payer or program.

Provider Responsibilities
Before confirming a visit in AuthentiCare to be submitted for claims processing, Provider Administrators will:

- Validate the information contained in the authorization including member, service, start and end dates, diagnosis code, ordering physician, number of approved units, and ensure that service rates are correct. If the claim billed amount is different than the calculated amount, the provider must update with their usual and customary billed amount. The provider is responsible for working with the payer to ensure a proper and accurate authorization is in the AuthentiCare system.
- Validate the visit information submitted by the caregiver.
- Address all critical exceptions found in the rules review process for visits in AuthentiCare by updating the visit information for accuracy, completeness and attesting to the accuracy of the visit information captured.
- Validate the TPL coverage information on the client record is accurate. If not, the provider will need to submit a request for an update through the KMMS provider portal.
- Validate the TPL adjudication information has been correctly entered on the claim for each TPL Payer.
- Validate and attest to the entry of all payor information related to Third Party Liability.
- Provider is responsible for the entry of TPL payments and CARC/RARCs and group codes in AuthentiCare.
- Confirm the visit for billing that will result in AuthentiCare building the claim and submitting it during its daily batch submission process.

Documenting Adjustments Using "Notes" in AuthentiCare Kansas
Providers must use the Notes field in the AuthentiCare Kansas web application whenever visit information is added, corrected, or otherwise adjusted. This includes changes to check-in time, check-out time, activity codes, units, or other visit information.

At a minimum, the note must identify:

- The person requesting the adjustment.
- The specific information added, removed, or changed.
- The reason for the adjustment.
- Whether the adjustment was confirmed with the member.

For example, a note may document that a 10:35 a.m. check-in was added because the caregiver forgot to check in, or that bathing was added and toileting was removed from the recorded activity codes following confirmation with the member.

Authorization Requirements
An authorization is required for every CSW service listed in this section. The authorization must contain sufficient information for AuthentiCare to associate the visit with the correct member, provider, service, procedure code, modifier, authorized period, and approved units.

The provider is responsible for working with the applicable payer when an authorization is missing, inaccurate, incomplete, expired, or does not contain sufficient units.

Ordering Provider Responsibilities
The CSW services listed in this section do not require ordering provider information on the EVV authorization.

When ordering provider information is required for another EVV-covered service, the MCO must include the ordering provider's first name, last name, and National Provider Identifier from CMS Form 485 in the authorization submitted to AuthentiCare.

If Form 485 is unavailable, the member's primary care provider or discharging physician may be used temporarily, when permitted under the applicable program requirements.

Diagnosis Code
MCOs must use the diagnosis code listed on Form 485. If Form 485 is unavailable, use R68.89 as the standard HCBS EVV diagnosis code.

Flexibility for Oversight
For EVV compliance, the authorization must include a provider who appropriately oversees the service plan within their professional scope. This may include a physician, primary care provider, discharging physician, or supervising therapist, depending on the service provided.

MCOs must follow these guidelines only in the context of authorization submission for EVV compliance. Any necessary clinical oversight or regulatory determinations remain the responsibility of providers in accordance with existing regulations.

Claims Adjustments
Providers may continue to submit claim adjustments through the KMMS Provider Portal. Providers must ensure that all required corrections and supporting documentation are submitted accurately and timely.

8400. HCBS CSW BENEFITS AND LIMITATIONS Updated 09/26

ASSISTIVE SERVICES

Service Definition

Assistive Services are supports, equipment, technology, modifications, or supplies that address a participant's assessed need by promoting health, independence, productivity, and community integration. Services must be directly related to goals and outcomes identified in the participant's Person-Centered Service Plan (PCSP) and support the participant's ability to function safely and independently within their home, workplace, or community.

Examples of Assistive Services include, but are not limited to:

- Wheelchair adaptations and modifications;
- Accessibility ramps and lifts;
- Bathroom and kitchen accessibility modifications;
- Communication devices and adaptive technology;
- Specialized medical equipment and supplies;
- Vehicle accessibility modifications; and
- Other devices and supports that improve participation in activities of daily living (ADLs), instrumental activities of daily living (IADLs), employment, or community activities.

To be covered, the service must meet at least one of the following objectives:

- Increase the participant's ability to live independently;
- Increase or enhance the participant's productivity;
- Improve the participant's health, welfare, or safety; or
- Promote participation and integration within the community.

All Assistive Services must be based on assessed need and authorized through the participant's PCSP.

Assistive Service Categories

The assistive services for the CSW program are categorized as follows:

1. Assistive Technology Services
    a. Assistive Technology Install/Equipment
    b. Assistive Technology Training
    c. Assistive Technology Consultation
2. Home and Environmental Modification Services (HEMS)
3. Vehicle Modification Services (VMS)
4. Specialized Medical Equipment and Supplies (SMES)

Service	Code-Modifier	Unit Definition	Covered Provider Specialty
Assistive Technology – Install/Equipment	T1999-U8	1 purchase	55/575, 55/576
Assistive Technology – Training	97535-U8	15-minute unit	55/575, 55/576
Assistive Technology – Consultation	97755-U8	1-hour consultation	55/577
HEMS	S5165-U8	1 purchase	55/575, 55/576
VMS	T2029-U8	1 purchase	55/575, 55/576
SMES	T2039-U8	1 purchase	55/575, 55/576

Assistive services are not subject to the Electronic Visit Verification (EVV) requirements.

1. ASSISTIVE TECHNOLOGY SERVICES

Assistive Technology is an item, piece of equipment, software, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve a participant's functional capabilities, independence, or vocational skills.

Assistive technology can be virtually delivered. Providers delivering services virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Prior to authorizing Assistive Technology services, the MCO must coordinate with other benefits the participant may have.

- The MCO must make attempts to identify potential community resources or natural supports.
- The MCO must request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments. This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.

Assistive technology services may include one or more of the following:

Assistive Technology Install/Equipment

- This service includes:
  - **Install –** installation of the equipment or ongoing costs for the service as necessary; and the cost of leasing, purchasing, or otherwise providing equipment. This cost may include engineering, designing, fitting, customizing, or adapting the equipment to meet a participant's specific needs, and
  - **Equipment** – the cost of leasing, purchasing, or otherwise providing equipment. This cost may include engineering, designing, fitting, customizing, or adapting the equipment to meet a participant's specific needs.

Billing or Service Code(s):

- The assistive technology installation/equipment services are covered when rendered by the provider type and specialties, **55/575** (Assistive Services (Center for Independent Living)) and/or **55/576** (Assistive Services – Individual Contractor/Direct Contractor). The providers must enroll under these specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T1999-U8	1 purchase	55/575, 55/576

Assistive Technology Training

- This service includes education and training beyond what is covered in the initial installation and training or through routine questions. Assistive technology support can be provided to the participant or the participant's unpaid caregivers, employers, or others who are substantially involved in activities being supported by the assistive technology equipment. When necessary, assistive technology support may include coordination with other related therapies or interventions and adjustments to existing assistive technology equipment to ensure it remains effective.

Assistive Technology Training continued

Billing or Service Code(s):

- The assistive technology installation/equipment services are covered when rendered by the provider type and specialties, **55/575** (Assistive Services (Center for Independent Living)) and/or **55/576** (Assistive Services – Individual Contractor/Direct Contractor). The providers must enroll under these specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
97535-U8	Each 15-minute	55/575, 55/576

Assistive Technology Consultation

This service includes consultation/evaluation of what assistive technology a participant needs, including how that technology would impact a participant's functional abilities.

Billing or Service Code(s):

- The assistive technology consultation/evaluation is covered when rendered by the provider type and specialties, **55/577** (Assistive Services Consultation). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
97755-U8	1-hr consultation	55/577

2. HOME AND ENVIRONMENTAL MODIFICATION SERVICES (HEMS)

- Home and Environmental Modification Services (HEMS) are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence and to create a safer, healthier environment.
- HEMS includes modifications to the environment, training on the use of the modification, or service and maintenance of the modification. Upon delivery to the participant (including installation), the HEMS adaptation must be in good operating condition and repair in accordance with applicable specifications.
- HEMS do not include:
  - Improvements of a residence that are of general utility
  - Improvements of a residence that are not of direct medical or remedial benefit to the participant or otherwise meets the needs of the participant as defined in instances above
  - Improvements of a residence that add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to the participant's access to the participant's primary residence
  - Improvements of a residence that are required by local, county, or State law when purchasing a residence
  - A generator for use other than to support the participant's medical and health devices that require electricity for safe operation
  - Traditional shafted elevator, other elevator, or escalator
  - Adaptations to living spaces that are owned or leased by providers of waiver services
    - All waiver services are limited to the participant's assessed needs and based on the participant's person-centered service plan. This service is limited to those services not duplicating other services or covered through the Medicaid State Plan, EPSDT, or any other formal or informal resources such as Vocational Rehabilitation or the educational system.
    - Participants will have the choice to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs. To determine an available, economically-viable option that meets a participant's assessed needs, the MCO must evaluate the most effective HEMS solution by completing a process that includes, but is not limited to the following:
- Prior to authorizing HEMS, the MCO must coordinate with other benefits the participant may have. The MCO must make attempts to identify potential community resources or natural supports.
- The MCO must request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments. This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.
- The MCO will request bids for HEMS. This process will not be completed when the MCO cannot find more than one provider/contractor to provide a bid.
- The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost. The MCO will not accept bids solely based on the cost proposed. Bids that do not meet the participant's needs, or bids submitted by contractors with a low work quality history will not be considered.

2. Home and Environmental Modification Services (HEMS) continued Updated 09/26

Billing or Service Code(s):

- The Home and Environmental Modification Services are covered when rendered by the provider type and specialties, **55/575** (Assistive Services – Center for Independent Living) and/or **55/576** (Assistive Services – Individual Contractor/Direct Contractor). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
S5165-U8	1 purchase	55/575, 55/576

3. VEHICLE MODIFICATION SERVICES (VMS)

- Vehicle Modification Services (VMS) are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications accommodate the health and safety needs of the participant and enable the participant to integrate more fully into the community by removing barriers to transportation.
- VMS include:
  - Assessment services:
    - To help determine what a participant needs as a driver or passenger
    - To review options to meet these needs
    - To develop a prescription for required modifications
  - Help buying the parts or service to modify a car owned or bought by the participant, a legally responsible parent of a minor, or other unpaid primary caretaker
  - Repairs for a modification on a vehicle that is not under warranty
  - Training on the use of the modification
- VMS exclude:
  - Purchase or lease of new or used vehicles
  - General vehicle maintenance or repair, except upkeep and maintenance of the modifications
  - State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties
  - Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual
    - Upon delivery to the participant (including installation), the vehicle modification must be in good operating condition and repair in accordance with applicable specifications.
    - All waiver services are limited to the participant's assessed needs and based on the participant's person-centered service plan. This service is limited to those services not duplicating other services or covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or any other formal or informal resources such as Vocational Rehabilitation or the educational system.
    - The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

3. Vehicle Modification Services (VMS) continued Updated 09/26

- Participants will have the choice to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs. To determine an available, economically viable option that meets a participant's assessed needs, the MCO shall evaluate the most cost-effective VMS solution by completing a process that includes, but is not limited to the following:
  - Prior to authorizing VMS, the MCO shall coordinate with other benefits the participant may have. The MCO shall make attempts to identify potential community resources or natural supports.
  - The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments. This helps determine the options available for meeting the participant's need, and which option may be the most cost-effective.
  - The MCO will request bids for VMS. This process will not be completed when the MCO cannot find more than one provider/contractor to provide a bid.
  - The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed, are covered, and are not of extraordinary cost. The MCO will not accept bids solely based on the cost proposed. Bids that do not meet the participant's needs or are bids submitted by contractors with a low work quality history will not be considered.

Billing or Service Code(s)

- The Vehicle Modification Services are covered when rendered by the provider type and specialties, **55/575** (Assistive Services – Center for Independent Living) and/or **55/576** (Assistive Services – Individual Contractor/Direct Contractor). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T2029-U8	1 purchase	55/575, 55/576

4. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SMES) UPDATED 09/26

- Specialized medical equipment and supplies (SMES) include:
  - Devices, controls, software, or appliances that enable participants to increase their ability to perform activities of daily living
  - Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items
  - Durable and non-durable medical equipment not available under the State plan that is necessary to address participant needs

SMES must meet applicable standards of manufacture, design, and installation.

- Some instances where SMES may be used can include, but are not limited to the following:
  - A participant may use SMES to supplement durable medical equipment (DME) furnished through the State plan, such as wheelchairs or walkers.
  - A participant may use SMES to purchase disposable non-durable equipment or supplies such as wipes or testing strips.

SMES does not include items that are not of direct medical or remedial benefit to the participant.

The coverage/provision of SMES furnished through this service shall include the costs of maintenance and upkeep of devices, and training on the utilization of the devices. This includes normal wear and tear. Intentional destruction or damage to a device will not be a covered cost.

- All waiver services are limited to the participant's assessed needs and based on the participant's person-centered service plan. This service is limited to those services not duplicating other services or covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or any other formal or informal resources such as Vocational Rehabilitation or the educational system.

Billing or Service Code(s)

- The Specialized Medical Equipment and Supplies (SMES) are covered when rendered by the provider type and specialties, **55/575** (Assistive Services – Center for Independent Living) and/or **55/576** (Assistive Services – Individual Contractor/Direct Contractor). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T2039-U8	1 purchase	55/575, 55/576

Provider Qualifications and Enrollment Requirements – Assistive Services

Assistive Services may be provided by:

- Centers for Independent Living (CILs) – **55/575**
- Individual Contractors (Direct Contractors) – **55/576**
- Non-KanCare Enrolled/Indirect Contractors
- Qualified Assistive Technology Consultants – **55/577**

All providers must meet applicable waiver requirements and are subject to annual qualification verification by the MCO, or by KDADS for tribal members receiving services through Fee-For-Service. Assistive Technology Consultants must possess one of the specified professional licenses, certifications, or educational qualifications required to perform assistive technology assessments and consultations.

Center for Independent Living (CIL)

- Qualifications:
  - Must operate as a Center for Independent Living in accordance with applicable state and federal requirements.
  - Must maintain all business licenses, certifications, registrations, and approvals required to provide assistive technology services.
  - Must ensure staff providing assistive technology services possess the education, training, experience, and credentials necessary to perform their assigned duties.
  - Provider qualifications are verified by the MCO. For tribal members receiving services through FFS, KDADS is responsible for provider qualification verification.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **575** (Assistive Services (CIL)) using taxonomy 2865C1500X (Community Health).
  - Required attachments are:
    - W9
    - Proof of CIL License
    - Proof of Business Establishment (2 consecutive years) or CIL
    - Proof of Worker's Compensation Certificate
    - Proof of General Liability Insurance
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.
  - Must ensure all rendering staff and subcontractors meet applicable service qualifications.

Provider Qualifications and Enrollment Requirements – Assistive Services continued

Individual Contractor (Direct Contractor)

- Qualifications:
  - Must meet all applicable qualifications for the Assistive Technology Services being provided.
  - Must be contracted with a KanCare MCO or approved as an out-of-network provider when applicable.
  - Must maintain any licenses, certifications, training, or experience required for the specific assistive technology service being delivered.
  - Provider qualifications are subject to annual verification by the MCO. For tribal members receiving services through FFS, KDADS is responsible for qualification verification.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **576** (Assistive Services (IC/DC)) using taxonomy 2865C1500X (Community Health).
  - Required attachments are:
    - W9
    - Proof of Business Establishment (2 consecutive years)
    - Proof of Worker's Compensation Certificate
    - Proof of General Liability Insurance
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must affiliate with the applicable KanCare MCO(s) as required.
  - Must maintain an active provider record and keep all enrollment information current.

Non-KanCare-Enrolled / Indirect Contractor

- Qualifications:
  - May provide services through an enrolled agency or contractor arrangement.
  - Must meet all qualifications required by the contracting entity and applicable waiver requirements.
  - Must maintain any required licenses, certifications, education, or experience applicable to the services performed.
  - Provider qualifications are verified by the supervising or contracting entity and are subject to review by the MCO or KDADS, as applicable.
- KMMS Enrollment:
  - Does not enroll independently in KMMS when operating solely as an indirect contractor under an enrolled agency.
  - Services are billed through the enrolled provider agency that employs or contracts with the individual.

Provider Qualifications and Enrollment Requirements – Assistive Services continued

Assistive Technology Consultant

- Qualifications:
  - An Assistive Technology Consultant must meet at least one of the following requirements:
    - Licensed Occupational Therapist;
    - Licensed Physical Therapist;
    - Licensed Speech-Language Pathologist;
    - Assistive Technology Professional (ATP) certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA);
    - Bachelor's degree and certification from a nationally recognized assistive technology assessment curriculum; or
    - Bachelor's degree and at least one year of experience as a technology-specific expert employed by a technology-specific provider.
    - In addition, the consultant must be contracted with a KanCare MCO or approved as an out-of-network provider. Qualifications are verified annually by the MCO or KDADS, as applicable.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **577** (Assistive Services Consultation) using taxonomy 2865C1500X (Community Health).
  - Required attachments are:
    - W9
    - Proof of OT/PT/SLP License OR RESNA ATP certification OR BA with AT assessment certificate OR BA with SME role for >=1 year
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must submit documentation supporting applicable licensure, certification, education, and experience requirements.
  - Must maintain current credentials at all times.

Assistive Services Limitations

General Limitations

- HCBS CSW Assistive Services are available to Medicaid members who:
  - Are five years of age or older
  - Are intellectually or otherwise developmentally disabled
  - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
  - Choose to receive HCBS I/DD rather than ICF-I/ID services
- HCBS CSW program services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through requirements relating to the deeming of parental income and who meet the criteria above.
- Purchase or rental of used assistive technology is limited to those items not covered through regular Medicaid.
- An outside party cannot be required to subsidize an assistive service request. The contractor must accept full payment from Medicaid.

Specific Limitations for Wheelchair Modifications

- Any wheelchair modification must be authorized by a registered physical therapist,
- identified as medically necessary (K.A.R. 30-5-58) by a physician and identified on the member's POC.
- This service can only be accessed after a member is no longer eligible for KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) services through the medical card.
- Wheelchair modifications must be specific to the individual member's needs and not utilized as general agency equipment.

Specific Limitations for Van Lifts (including repair and maintenance)

- Van lifts purchased must meet any engineering and safety standards recognized by the secretary of the U.S. Department of Transportation.
- Van lifts can only be installed in family vehicles or vehicles owned or leased by the member. A van lift must not be installed in an agency vehicle unless an informed exception is made by the Kansas Department for Aging and Disability Services – Community Services and Programs (KDADS-CSP).

Specific Limitations for Communication Devices

- Communication devices will only be purchased when recommended by a speech pathologist.
- Communication devices can only be accessed after a member is no longer eligible to receive services through the local education system.
- Communication devices are purchased for use by the individual member only not for use as agency equipment.

Specific Limitations for Home Modifications

- Home modifications must not increase the finished square footage of an existing structure.
- Home modifications must not be accessed for new construction.
- Home modifications must be used on property the member leases or owns, or in the family home if still living there, but not on agency owned and operated property unless an informed exception is made by KDADS-CSP.

Documentation Requirements – Assistive Services

- Record-keeping responsibilities rest primarily with the Medicaid-enrolled provider.
- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
  - Copy of the receipt identifying that the service was provided
  - Name of the business or contractor
  - Identification of the service being provided
  - Date of service (MM/DD/YY)
  - Amount of purchase
  - Member's first and last name and signature (see Signature Limitations)
  - Note: **Regardless of who signs it, the member's name must be on the form.**
  - Statement of inspection by provider to ensure product was purchased or installed as authorized
- Documentation must include a brief description of the service provided. Certain responsibilities may be passed to performing providers of the service.
- Documentation must be created during the time period of the billing cycle. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

BENEFITS PLANNING

Service Definition

Benefits Planning Services help participants and their family members or unpaid caregivers understand how employment may impact the participant's public benefits. The service provides individualized guidance to support informed employment decisions while maximizing financial self-sufficiency and maintaining access to essential benefits.

Benefits Planning Services assist participants in understanding the relationship between earned income and public assistance programs, including:

- Supplemental Security Income (SSI);
- Medicaid;
- Social Security Disability Insurance (SSDI);
- Medicare;
- Food and nutrition assistance programs;
- Housing assistance programs;
- Achieving a Better Life Experience (ABLE) accounts; and
- Other applicable federal, state, or local benefits.

Certified Benefits Planners help participants identify available work incentives and determine how employment may affect their overall financial situation. The goal of the service is to increase access to employment opportunities by providing accurate, individualized information regarding the impact of work and earned income on public benefits.

Covered Services

Benefits Planning Services will provide information, education, consultation, and technical assistance for the participant regarding:

- Verifying their benefits and planning for the future
- Developing Plans for Achieving Self Sufficiency (PASS) and Property Essential to Self-Support (PESS)
- Coordinating work incentives across multiple benefit programs
- Reporting their income for public benefit programs, including the Social Security Administration

Benefits Planning Services may be provided:

- To participants considering competitive integrated employment.
- To participants seeking career advancement opportunities.
- To participants requiring assistance resolving financial issues that may affect their ability to obtain or maintain employment.

Participants may choose either:

- In-person service delivery; or
- Virtual service delivery.

Providers delivering services virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Service Limitations

Benefits Planning Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's Person-Centered Service Plan (PCSP).
- Support employment-related decision making and financial self-sufficiency.
- Be directly related to understanding, preserving, or maximizing public benefits while pursuing employment.

Benefits Planning Services may not duplicate services available through:

- The Medicaid State Plan;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
- Vocational Rehabilitation;
- Educational services;
- Other waiver services; or
- Any other formal or informal resources available to the participant.

Non-Covered Services

Benefits Planning Services

- May not duplicate benefits counseling services funded through another program or funding source.
- May not include legal representation or legal advocacy services.
- May not include services unrelated to employment planning, work incentives, or public benefit coordination.

Billing or Service Code(s)

- The Benefit Planning services are covered when rendered by the provider type and specialties, **55/580** (Benefits Planning – Benefits Planning Agency (BPA)/Certified Benefits Planner (CBP)). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T2019-U8	One 15-minute unit	55/580

Benefits Planning services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Benefits Planning

Benefits Planning Services may be provided by:

- Benefits Planning Agency or Certified Benefits Planner – **55/580**

Benefits Planning Agency

- Qualifications:
- A Benefits Planning Agency must:
  - Employ staff who maintain a current Community Partner Work Incentive Counseling (CPWIC) certification, Community Work Incentives Coordinator (CWIC) certification, Work Incentive Practitioner Credential (WIP-C), or another certification accepted by the Social Security Administration (SSA) for its Work Incentives Planning and Assistance (WIPA) program.
  - Be contracted with a KanCare MCO or approved as an out-of-network provider.
  - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **580** (Benefits Planning Services using taxonomy 2865C1500X (Community Health).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of CPWIC, CWIC, or WIP-C certification or other WIPA cert accepted by SSA
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.
  - Must ensure all rendering staff and subcontractors meet applicable service qualifications.

Certified Benefits Planner

- Qualifications:
  - A Certified Benefits Planner must maintain a current:
    - Community Partner Work Incentive Counseling (CPWIC) certification; or
    - Community Work Incentives Coordinator (CWIC) certification; or
    - Work Incentive Practitioner Credential (WIP-C); or
    - Another certification accepted by the Social Security Administration (SSA) for its Work Incentives Planning and Assistance (WIPA) program.
    - Be contracted with a KanCare MCO or approved as an out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **580** (Benefits Planning Services using taxonomy 2865C1500X (Community Health).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of CPWIC, CWIC, or WIP-C certification or other WIPA cert accepted by SSA
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

CAREER EXPLORATION AND PLANNING

Service Definition

Career Exploration and Planning is a person-centered employment service designed to assist participants in identifying, pursuing, and achieving competitive integrated employment or self-employment. The service helps participants explore career opportunities, identify employment goals, develop meaningful career plans, and build the skills necessary to pursue sustainable employment that promotes independence, self-sufficiency, and community inclusion.

Consistent with the Kansas Employment First Act and federal competitive integrated employment requirements, providers shall encourage and prioritize employment opportunities that:

- Occur in integrated community settings;
- Are comparable to employment opportunities available to the general workforce;
- Pay wages at or above the minimum wage and not less than the customary wage paid to individuals without disabilities performing similar work; and
- Provide benefits comparable to those offered to employees without disabilities in similar positions.

Covered Services

Career Exploration and Planning Services include activities that help participants identify employment goals, increase job readiness, and pursue competitive integrated employment.
Core components of the service include:

- **Job Exploration:** Helping participants explore potential career paths, understand industry requirements, and assess their skills and interests.
- **Job Search:** Assisting participants to identify job openings.
- **Resume Management:** Providing guidance on creating effective resumes, tailoring them to specific job applications, and managing professional documents.
- **Job Application:** Supporting participants throughout the job application process, including completing applications, following up, and negotiating offers.
- **Interview Preparation and Support:** Providing practice interviews, coaching on interview techniques, and offering advice on answering common interview questions.
- **Community Outreach Calls:** Facilitating outreach to potential employers through outreach calls, networking events, or industry connections.

Career Exploration and Planning may be provided:

- On an individual basis or in a group setting.
- In the participant's residence.
- At a provider's place of business.
- In community-based settings.

Participants may choose either in-person or virtual service delivery. Providers delivering services virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Transportation provided within the context of Career Exploration and Planning activities is included in the service rate and is not separately reimbursable.

Transportation between the participant's residence and the service location, or transportation unrelated to approved Career Exploration and Planning activities, is not covered under this service.

Collaboration with Vocational Rehabilitation (VR)

Career Exploration and Planning Services must be coordinated with available Vocational Rehabilitation (VR) services and may not duplicate services funded through the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA), or other comparable programs.

Documentation must demonstrate that Career Exploration and Planning activities are not duplicative of available VR services.

Career Exploration and Planning services may be authorized when:

- The participant has completed Vocational Rehabilitation services;
- The participant has been determined ineligible for Vocational Rehabilitation services;
- The participant is on a waiting list for Vocational Rehabilitation services; or
- Vocational Rehabilitation services are otherwise unavailable to the participant.

Prior to authorization, the participant must have applied for Vocational Rehabilitation services through the appropriate local VR office.

Documentation verifying one of the following must be maintained in the participant's file and made available upon request:

- Completion of Vocational Rehabilitation services;
- Ineligibility determination issued by DCF Vocational Rehabilitation;
- Waiting list status for Vocational Rehabilitation services; or
- Documentation demonstrating VR services are not available.

Career Exploration and Planning services may be authorized during a Vocational Rehabilitation waiting period and shall terminate upon initiation of approved Vocational Rehabilitation services when those services duplicate waiver-funded activities.

Service Limitations

Career Exploration and Planning Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Focus on employment exploration, planning, job readiness, and career development.
- Support movement toward competitive integrated employment or self-employment outcomes.

Career Exploration and Planning Services may not duplicate services available through:

- The Medicaid State Plan;
- EPSDT;
- Vocational Rehabilitation;
- Educational services;
- Other waiver services; or
- Any other formal or informal supports available to the participant.

Non-Covered Services

Career Exploration and Planning Services:

- May not duplicate services funded through Vocational Rehabilitation, educational programs, or other employment-related funding sources.
- May not be provided when equivalent services are readily available through another program or funding source.
- Do not include ongoing job coaching or employment retention activities, which are covered under Individual Employment Support Services.
- Do not include transportation between the participant's residence and the service location.

Billing or Service Code(s)

- The Career Exploration and Planning services are covered when rendered by the provider type and specialties, **55/581** (Career Exploration and Employment Support). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
H2023-U1, Individual	One 15-minute unit	55/581
H2023-U3, Group	One 15-minute unit	55/581

Career Exploration and Planning services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Career Exploration and Planning

Career Exploration and Planning Services may be provided by:

- Employment Support Professional or Employment Support Agency – **55/581**

Employment Support Professional

- Qualifications:
  - An Employment Support Professional must:
    - Maintain an industry-recognized employment support certification, including one of the following:
      - Association of People Supporting Employment First (APSE) Credentialed Employment Support Professional (CESP) certification;
      - Association of Community Rehabilitation Educators (ACRE) Employment Services Basic Certification;
      - ACRE Employment Services Professional Certification;
      - ACRE Customized Employment Basic Certification; or
      - ACRE Customized Employment Professional Certification.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
    - Complete annual KDADS-approved training covering:
      - Restraint;
      - Restrictive interventions;
      - Crisis prevention, including positive behavioral supports; and
      - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **581** (Career Exploration and Employment Support using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of APSE/CESP/ACRE certification
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Employment Support Agency

- Qualifications:
  - An Employment Support Agency must:
    - Employ staff providing Individual Employment Support (IES) services who maintain an industry-recognized employment support certification, including one of the following:
      - Association of People Supporting Employment First (APSE) Credentialed Employment Support Professional (CESP) certification;
      - Association of Community Rehabilitation Educators (ACRE) Employment Services Basic Certification;
      - ACRE Employment Services Professional Certification;
      - ACRE Customized Employment Basic Certification; or
      - ACRE Customized Employment Professional Certification.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Ensure all staff delivering direct services and supports:
      - Are authorized to work in the United States;
      - Meet all applicable employment standards established by the employing agency; and
      - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
        - Abuse, neglect, and exploitation prevention;
        - State law reporting requirements related to abuse, neglect, and exploitation;
        - Cardiopulmonary Resuscitation (CPR); and
        - Basic First Aid.
    - Ensure staff complete annual KDADS-approved training covering:
      - Restraint;
      - Restrictive interventions;
      - Crisis prevention, including positive behavioral supports; and
      - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency Provider under provider specialty **581** (Career Exploration and Employment Support using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of APSE/CESP/ACRE certification
    - Attestation: IES Staff Certification
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

FAMILY/CAREGIVER SUPPORT AND TRAINING (FCST)

Service Definition

Family/Caregiver Support and Training (FCST) provides education, coaching, training, consultation, and support to family members and unpaid caregivers who provide ongoing care, supervision, companionship, or support to a participant. The service is designed to strengthen the caregiver's ability to effectively support the participant while promoting caregiver well-being and reducing caregiver stress.

FCST may only be provided to family members/unpaid caregivers who provide unpaid support, companionship, or supervision to a participant. FCST may not be used to train paid caregivers or direct support staff.

Services must be directly related to the caregiver's role in supporting the participant and must support goals and outcomes identified in the participant's PCSP.

Covered Services

FCST may include activities that improve the caregiver's ability to support the participant in the home and community environment.

- Caregiver Education, Coaching, and Training
  - Education regarding the participant's disability, support needs, and service plan goals.
  - Training on strategies to provide a safe and supportive living environment.
  - Coaching to improve caregiving skills and confidence.
  - Guidance on effectively supporting participant independence and community involvement.
- Caregiver Wellness and Support
  - Identifying and implementing healthy coping strategies.
  - Reducing caregiver stress and strain.
  - Improving caregiver self-care practices.
  - Strengthening social and community supports available to caregivers.
- Skill Development and Problem Solving
  - Developing problem-solving skills related to participant needs.
  - Training on behavior support strategies and symptom management techniques.
  - Building communication and conflict-resolution skills.
  - Increasing caregiver knowledge regarding participant-specific support needs.
- Waiver Education and Navigation
  - Training related to HCBS waiver requirements and processes.
  - Education regarding crisis planning and risk management.
  - Assistance understanding service planning and service authorization processes.
  - Information regarding respite services and how to access them.
- Community Resource Education
  - Information regarding community-based services and supports available outside the waiver program.
  - Assistance identifying natural supports and community resources that may benefit the participant and caregiver.

Covered Services continued

Family/Caregiver Support and Training may be delivered:

- Individually; or
- In a group setting.

Group services:

- May include no more than four families/unpaid caregivers at one time.
- Require agreement by participating caregivers to receive services in a group setting.
- Must consist of caregivers who each provide support to an HCBS participant.

Participants and caregivers may choose:

- In-person service delivery; or
- Virtual service delivery.

Providers delivering services virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Participant Responsibilities

- Participants who self-direct FCST services are responsible for:
  - Selecting and employing qualified Peer Providers.
  - Ensuring the Peer Provider possesses the knowledge, experience, and skills necessary to support family members and unpaid caregivers.
  - Providing participant-specific information and training necessary to achieve the goals identified in the PCSP.
  - Monitoring service quality and ensuring services are delivered in accordance with the approved service plan.

Service Limitations

Family/Caregiver Support and Training must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Be directly related to supporting the participant's goals, needs, and outcomes.
- Improve the caregiver's ability to provide support to the participant.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports available to the participant.

Non-Covered Services

Family/Caregiver Support and Training:

- May not be used to train paid caregivers, direct support staff, or provider employees.
- May not include direct care services delivered to the participant.
- May not substitute for therapy, counseling, or treatment services otherwise covered through another funding source.
- May not duplicate caregiver education or training available through another program or provider.

Billing or Service Code(s)

- The Family/Caregiver Support and Training services are covered when rendered by the provider type and specialties, **55/570** (FCST-Center for Independent Living), **55/571** (FCST-Licensed Mental Health Professional), **55/572** (FCST-Community Support Provider), **55/573** (FCST-Community Mental Health Center) or **55/530** (FCST Peer Provider in agreement with Financial Management Services (FMS) for the self-directed services. The providers must enroll under the listed specialties to be eligible for the reimbursement.

Agency-Directed FCST

Code-Modifier	Unit Definition	Covered Provider Specialty
S5110-U1, Group	Each 15-minute	55/570, 55/571, 55/572, 55/573
S5110-U8, Individual	Each 15-minute	55/570, 55/571, 55/572, 55/573

FCST services are not subject to the EVV requirements.

Self-Directed FCST

Code-Modifier	Unit Definition	Covered Provider Specialty
S5110-U2, Individual	Each 15-minute	55/530
S5110-U3, Group	Each 15-minute	55/530

FCST services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – FCST

FCST services may be provided by:

- Center for Independent Living (CIL) – **55/570**
- Licensed Mental Health Professional (LMHP) – **55/571**
- Community Support Provider (CSP) – **55/572**
- Community Mental Health Center (CMHC) – **55/573**
- Family/Caregiver Support Peer Provider – **55/530 (FMS)**

Center for Independent Living (CIL)

- Qualifications:
  - A Center for Independent Living must:
    - Receive state or federal grant funding for independent living services as authorized under the Rehabilitation Act of 1973, as amended.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The CIL should ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - CIL staff delivering this service must:
    - Have a high school diploma or equivalent;
    - Be 21 years of age or older;
    - Complete parent support training or other KDADS-approved training curriculum; and
    - Complete an annual KDADS-approved training.
  - The CIL should ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **570** (Family/Caregiver Support and Training (CIL) using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CIL
    - Proof of CDDO Affiliation
    - Attestation: FCST Staff Eligibility & Training
    - Attestation: FCST Parent Support Training
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Licensed Mental Health Professional (LMHP)

- Qualifications:
  - A Licensed Mental Health Professional (LMHP) providing FCST services must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain all applicable professional licensure, certification, registration, and practice requirements required under Kansas law.
    - Complete Parent Support Training or another KDADS-approved training curriculum applicable to Family/Caregiver Support and Training services.
  - The LMHP shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The LMHP shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention,
  - The LMHP shall possess the knowledge, skills, and competencies necessary to:
    - Educate and support family members and unpaid caregivers;
    - Develop caregiver coping and problem-solving strategies;
    - Provide caregiver coaching and skill development;
    - Support behavior management and disability-specific caregiver training; and
    - Assist families in navigating HCBS waiver services, community resources, and participant support systems.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **571** (Family/Caregiver Support and Training (LMHP) using taxonomy 104100000X (Social Worker)).
  - Required attachments are:
    - W9
    - Proof of KSBSRB License
    - Proof of CDDO Affiliation
    - Attestation: FCST Staff Eligibility & Training
    - Attestation: FCST Parent Support Training
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Community Support Provider (CSP)

- Qualifications:
  - A Community Support Provider (CSP) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Ensure staff delivering direct services and supports:
      - Are authorized to work in the United States.
      - Meet all applicable employment standards established by the employing agency.
      - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
        - Abuse, neglect, and exploitation prevention;
        - State law reporting requirements related to abuse, neglect, and exploitation;
        - Cardiopulmonary Resuscitation (CPR); and
        - Basic First Aid.
  - Community Service Provider delivering this service must:
    - Have a high school diploma or equivalent;
    - Be 21 years of age or older;
    - Complete parent support training or other KDADS-approved training curriculum; and
    - Complete an annual KDADS-approved training.
  - Ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **572** (Family/Caregiver Support and Training (CSP) using taxonomy 251S00000X (Community / Behavioral Health)).
  - Required attachments are:
    - W9
    - Proof of CSP License
    - Proof of CDDO Affiliation
    - Attestation: FCST Staff Eligibility & Training
    - Attestation: FCST Parent Support Training
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Community Mental Health Center (CMHC)

- Qualifications:
  - A Community Mental Health Center (CMHC) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain all applicable state licenses, certifications, and approvals required to operate as a Community Mental Health Center in Kansas.
  - CMHC staff delivering this service must:
    - Have a high school diploma or equivalent;
    - Be 21 years of age or older;
    - Complete parent support training or other KDADS-approved training curriculum; and
    - Complete an annual KDADS-approved training.
  - The CMHC shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The CMHC shall ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **573** (Family/Caregiver Support and Training (CMHC) using taxonomy 261QM0801X (Community Mental Health Center)).
  - Required attachments are:
    - W9
    - Proof of CMHC License
    - Proof of CDDO Affiliation
    - Attestation: FCST Staff Eligibility & Training
    - Attestation: FCST Parent Support Training
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Family/Caregiver Support Peer Provider (Self-directed FCST)

- Qualifications:
  - A Family/Caregiver Support Peer Provider hired by a participant who elects to self-direct services must:
    - Enter into an employment or provider agreement with the Financial Management Services (FMS) entity authorized to support self-directed services.
    - Meet all requirements established under the participant-directed service model and applicable federal and state employment regulations.
  - A Family/Caregiver Support Peer Provider must:
    - Possess a high school diploma or equivalent.
    - Be 21 years of age or older.
    - Successfully complete Parent Support Training or another KDADS-approved training curriculum applicable to Family/Caregiver Support and Training services.
  - The Family/Caregiver Support Peer Provider shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - It is preferred, but not required, that the Family/Caregiver Support Peer Provider:
    - Has at least three years of direct caregiving experience supporting an individual with an intellectual or developmental disability; or
    - Is a family member or relative of an individual with an intellectual or developmental disability and has personal experience navigating disability-related support systems.
- KMMS Enrollment:
  - Individual FCST Peer Providers are not required to enroll as providers in KMMS/KMAP; however, they must have a valid provider agreement with the participant's FMS entity before delivering and billing for self-directed FCST services.

HOME TELE-HEALTH

Service Definition

Home Telehealth Services provide remote health monitoring and disease management support to help participants effectively manage one or more chronic health conditions and identify early warning signs before a health crisis occurs. The service combines remote monitoring technology, participant education, counseling, and nursing oversight to improve health outcomes, increase self-management skills, and reduce avoidable hospitalizations and emergency room visits.

Home Telehealth Services are designed to support participants in managing chronic conditions such as:

- Chronic Obstructive Pulmonary Disease (COPD);
- Congestive Heart Failure (CHF);
- Hypertension;
- Diabetes; and
- Other qualifying health conditions approved through the participant's service plan.

The service promotes participant engagement through ongoing monitoring, education, and personalized interventions that encourage adherence to prescribed treatments, medications, diet, exercise, and self-management practices.

Covered Services

Home Telehealth Services may include:

- Remote Monitoring
  - Ongoing monitoring of health status through approved telemonitoring technology.
  - Collection and review of health-related data, including vital signs and participant responses.
  - Identification of changes or trends requiring follow-up or intervention.
  - Early detection of potential health concerns to prevent unnecessary hospitalizations or emergency room utilization.
- Disease Management and Education
  - Education regarding disease processes and symptom management.
  - Instruction on recognizing and reporting symptoms.
  - Support for medication compliance.
  - Education related to nutrition, exercise, and healthy lifestyle practices.
  - Training to improve self-management skills and participant independence.
- Clinical Monitoring and Nursing Oversight
  - Review of participant baseline measurements and health indicators.
  - Ongoing monitoring by a licensed nurse.
  - Follow-up when vital signs or participant responses indicate a potential health concern.
  - Coordination with the participant's physician and healthcare team as needed.
- Equipment and Technology Support
  - Installation and setup of remote monitoring equipment.
  - Participant and caregiver training on equipment operation and use.
  - Technical assistance and support related to approved telehealth equipment.

Covered Services continued

Remote monitoring technology may include, but is not limited to:

- Cardiac telemonitoring systems;
- Vital sign telemonitoring systems;
- Telemonitoring systems with teleconsultation capabilities;
- Telemonitoring mattresses;
- Web-based monitoring applications;
- Mobile or smartphone applications; or
- Other approved monitoring technologies.

Equipment must be located within the participant's residence and in an environment appropriate for its intended use.

Service Delivery Requirements

Home Telehealth Services:

- Supplement, but do not replace, routine physician visits and healthcare services.
- Must be coordinated with the participant's healthcare providers.
- Must include participant education, counseling, and nursing supervision.
- Must include training for participants and caregivers regarding equipment operation and disease management.

The provider shall:

- Install approved equipment within 10 working days of service authorization.
- Review participant baseline health information established by the participant's physician.
- Monitor participant data and health indicators on an ongoing basis.
- Provide at least monthly participant contact to reinforce positive self-management behaviors.
- Submit monthly status reports to the participant's physician and MCO Care Coordinator.

A documented backup plan must be included within the participant's PCSP to address equipment failures or communication interruptions. The backup plan must identify response procedures and timeframes to prevent potential health or safety risks.

Participant Eligibility

Home Telehealth Services are available only when the participant:

- Has experienced two or more hospitalizations, including emergency room visits, within the previous year related to one or more chronic health conditions; or
- Is transitioning from a nursing facility to the community through the HCBS Institutional Transition process; and
- Has access to a functioning landline, wireless connection, or other approved communication method necessary to support the service.

Exclusions and Non-Covered Services

Home Telehealth Services are not available to participants residing in:

- Assisted Living Facilities;
- Residential Health Care Facilities; or
- Home Plus settings.

The service may not be authorized when:

- There is a prior authorization for Medicaid Home Telehealth Skilled Nursing Services Medicaid program; or
- The service would duplicate benefits available through:
- The Medicaid State Plan;
- EPSDT;
- Medicare Telehealth;
- Other waiver services; or
- Any other formal or informal supports available to the participant.

Home telehealth services are not a duplication of Medicare/Medicaid telehealth services. While the Kansas legislature calls this service home telehealth, the actual service follows the CMS telemonitoring definition, which Medicare does not cover. Home telehealth is a daily monitoring of the participant's vital sign measurements from the participant's home setting to attempt to divert a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and psychiatry services, usually through video contact.

Privacy and Participant Rights

All Home Telehealth Services must comply with applicable federal and state privacy and confidentiality requirements.

Participants must:

- Maintain control over the monitoring equipment;
- Initiate monitoring activities;
- Be informed regarding the collection and use of health information; and
- Have their privacy rights protected at all times.

Service Continuation Requirements

If a participant does not engage in required daily monitoring activities for seven consecutive days, the provider must notify the MCO Care Coordinator to determine whether continuation of the service remains appropriate.

Service Limitations

Home Telehealth Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's Person-Centered Service Plan (PCSP).
- Support the management of one or more documented health conditions.
- Include participant education and ongoing nursing oversight.
- Be used in conjunction with, rather than in place of, routine healthcare services.

Billing or Service Code(s)

- The Home Telehealth services are covered when rendered by the provider type and specialties, **55/587** (Home Telehealth Services-Home Health Agency) or **55/588** (Home Telehealth Services-County Health Department). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
S0315-U8, Installation	One Installation	55/587, 55/588
S0317-U8, Rental	Per day	55/587, 55/588

EVV is optional for Home Tel-health Services. Providers choosing to utilize EVV must comply with all applicable EVV requirements and documentation standards.

Provider Qualifications And Enrollment Requirements – Home Telehealth

Home Telehealth services may be provided by:

- Home Health Agency (HHA) – **55/587**
- County Health Department (CHD) – **55/588**

Home Health Agency (HHA)

- Qualifications:
  - A Home Telehealth Provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain and operate a remote monitoring system capable of monitoring participant health status on a daily basis.
    - Utilize equipment capable of monitoring, at a minimum:
      - Heart Rate;
      - Blood Pressure;
      - Mean Arterial Pressure (MAP);
      - Weight;
      - Oxygen Saturation; and
      - Temperature.
    - Utilize technology capable of presenting diagnosis-specific questions and monitoring protocols tailored to the participant's healthcare needs.
    - Ensure the monitoring system, associated equipment, and provider staff are capable of communicating with the participant in the participant's preferred language.
  - The Home Telehealth Provider shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.

Home Health Agency (HHA) continued

- The provider shall ensure staff possess the knowledge and competencies necessary to:
  - Train participants and caregivers on proper use of remote monitoring equipment.
  - Monitor participant health information and identify potential health concerns requiring follow-up.
  - Support disease management, participant education, and ongoing self-management activities.
  - Coordinate with physicians, care coordinators, and other healthcare professionals, as appropriate.

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **587** (Home Telehealth Services (HHA) using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Home Telehealth Equipment & Language Capability
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

County Health Department (CHD)

- Qualifications:
  - A County Health Department Provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain and operate a remote monitoring system capable of monitoring participant health status on a daily basis.
    - Utilize equipment capable of monitoring, at a minimum:
      - Heart Rate;
      - Blood Pressure;
      - Mean Arterial Pressure (MAP);
      - Weight;
      - Oxygen Saturation; and
      - Temperature.
    - Utilize technology capable of presenting diagnosis-specific questions and monitoring protocols tailored to the participant's healthcare needs.
    - Ensure the monitoring system, associated equipment, and provider staff are capable of communicating with the participant in the participant's preferred language.

County Health Department (CHD) continued

- The County Health Department Provider shall ensure that staff delivering direct services and supports:
  - Are authorized to work in the United States.
  - Meet all applicable employment standards established by the employing agency.
  - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
    - Abuse, neglect, and exploitation prevention;
    - State law reporting requirements related to abuse, neglect, and exploitation;
    - Cardiopulmonary Resuscitation (CPR); and
    - Basic First Aid.
- The provider shall ensure staff possess the knowledge and competencies necessary to:
  - Train participants and caregivers on proper use of remote monitoring equipment.
  - Monitor participant health information and identify potential health concerns requiring follow-up.
  - Support disease management, participant education, and ongoing self-management activities.
  - Coordinate with physicians, care coordinators, and other healthcare professionals, as appropriate.

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **588** (Home Telehealth Services (CHD) using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Home Telehealth Equipment & Language Capability
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

INDIVIDUAL DIRECTED GOODS AND SERVICES

Service Definition

- The Individual-Directed Goods and Services (IDGS) are services, equipment, supplies, or other supports that are not otherwise available through the Community Support Waiver, the Medicaid State Plan, or another funding source and are necessary to meet a participant's identified needs and goals. IDGS are intended to increase independence, promote community participation, enhance health and safety, and support successful community living.
- IDGS provide participants exercising budget authority with greater flexibility to purchase individualized supports that directly address needs identified in the participant's PCSP. Services and items must be selected and directed by the participant and must be used exclusively for the participant's benefit.

Covered Services

- IDGS may include services, equipment, supplies, or supports that:
  - Increase the participant's independence and self-sufficiency.
  - Improve health, safety, and well-being.
  - Support participation in community activities and community inclusion.
  - Assist the participant in achieving goals identified in the Person-Centered Service Plan (PCSP).
  - Reduce reliance on other Medicaid-funded services when appropriate.
  - Address a specific need that cannot be met through another available resource.
    - Examples may include individualized supports, specialized equipment, adaptive items, community integration resources, or other participant-directed purchases that meet program requirements.

Eligibility Criteria

- To be approved, an Individual-Directed Good or Service must satisfy all of the following requirements:
  - Decrease the need for other Medicaid services, promote community inclusion, or increase the participant's safety in the home or community.
  - Address a documented need identified in the participant's PCSP.
  - Support the participant in achieving one or more goals identified in the PCSP.
  - Be unavailable through the Medicaid State Plan or any other federal, state, local, private, or community resource.
  - Be unaffordable to the participant without waiver funding.
  - Be acquired using the most cost-effective option, including rental, lease, or purchase, as appropriate.
  - Not be experimental in nature.
  - Be accommodated within the participant's approved budget without compromising health or safety needs.
  - Be used solely for the benefit of the participant.
  - Comply with all applicable federal and state laws, regulations, and waiver requirements.
- IDGS are available only to participants who:
  - Elect to self-direct waiver services; and
  - Exercise budget authority under the HCBS Community Support Waiver.
- IDGS are purchased through the participant-directed budget and must be approved through the applicable planning, budgeting, and authorization processes prior to purchase.
- Participants are responsible for working with their TCM, Financial Management Services (FMS) entity, and MCO, as applicable, to ensure requested goods and services meet program requirements and remain within the approved participant budget.

Service Limitations

- Individual-Directed Goods and Services must:
  - Be based on the participant's assessed needs.
  - Be authorized through the participant's PCSP.
  - Be directly related to a documented participant goal, outcome, or support need.
  - Be cost-effective and fiscally responsible.
  - Not duplicate services or items available through:
    - The Medicaid State Plan;
    - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
    - Vocational Rehabilitation;
    - Educational services;
    - Other waiver services;
    - Private insurance; or
    - Any other formal or informal support or funding source.

Non-Covered Services

- IDGS may not include:
  - Experimental treatments, devices, or services.
  - Items prohibited by federal or state law or regulation.
  - Services or supports available from another funding source.
  - Purchases that are not directly related to the participant's identified needs or goals.
  - Items that primarily benefit family members, caregivers, providers, or other individuals.
  - Goods or services that exceed the participant's approved budget authority.

Billing or Service Code(s)

- The Individual Directed Goods and Services are covered when billed by the provider type and specialty, **55/530** (Financial Management Services). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T2028-U8	One purchase	55/530

Individual Directed Goods and Services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – IDGS

Self-Directed Individual Directed Goods and Services may be provided:

- Via Financial Management Services – **55/530**

INDIVIDUAL EMPLOYMENT SUPPORTS (IES)

Service Definition

Individual Employment Support Services provide individualized, job-related support to assist participants in obtaining, maintaining, and advancing in competitive integrated employment, customized employment, or self-employment. Consistent with the Kansas Employment First Act and federal competitive integrated employment requirements, IES supports participants in achieving meaningful employment opportunities within the general workforce and earning wages and benefits comparable to those received by individuals without disabilities performing similar work.

IES Services are person-centered and tailored to the participant's unique strengths, interests, skills, and employment goals. Services are designed to promote workplace success, increase independence, enhance job satisfaction, and support long-term career development.

Covered Services

Core service components include:

I. **Job Coaching and Retention Support:** Providing tailored assistance to build job-specific skills, address workplace challenges, and foster independence within the participant's chosen career path. Maintaining continued contact with the employer and employee and develop plans to fade daily support needs.
II. **Collaboration:** Employment specialists from the provider's team must work collaboratively with participants and employers to provide guidance, coaching, and problem-solving strategies for long-term job success. Working with employers to identify areas for job carving potential or special accommodations. Analyzing job functions and needed support to enable independence
III. **Maximizing Potential:** Actively supporting the participant's potential, identifying ways to enhance job satisfaction, and promoting the participant’s integration within the workplace.
IV. **Person-Centered Assessments:** Conducting assessments to understand the participant’s strengths, skills, and career goals.

IES Services:

- Are provided on a one-to-one basis.
- Occur at the participant's place of employment or business location.
- May be delivered through in-person or virtual service delivery.

Providers delivering virtual services must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Transportation necessary to support service delivery, including transportation within the context of IES activities and transportation between the participant's residence and place of employment, is included in the service rate and is not reimbursed separately.

Collaboration with Vocational Rehabilitation (VR)

IES Services shall not duplicate services available through the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA), Vocational Rehabilitation (VR), or other comparable programs. Documentation must demonstrate that VR resources have been explored and that IES Services are not duplicative of available VR services.

IES Services may be authorized when:

- The participant has completed Vocational Rehabilitation services;
- The participant has been determined ineligible for Vocational Rehabilitation services;
- Vocational Rehabilitation services are not readily available to the participant; or
- The participant is on a waiting list for Vocational Rehabilitation services.

Collaboration with Vocational Rehabilitation (VR) continued

Documentation supporting Vocational Rehabilitation status must be maintained in the participant's record and made available upon request.

Service Authorization Requirements

Participants eligible to receive employment-related services through a local education authority may receive IES Services only when all of the following criteria are met:

- The participant is at least 18 years of age;
- The participant will graduate from high school prior to age 22; and
- The participant is not receiving a substantially similar service through an Individualized Education Program (IEP).

A transition plan that includes employment goals and options must be maintained and made available upon request.

Participation Requirements

Participants receiving IES Services must:

- Be actively engaged in employment or employment-related activities occurring outside the participant's home; or
- Operate a home-based business consistent with approved employment goals.

This requirement is intended to support community participation and employment outcomes and shall not be used as a basis to require a participant to leave their home when not otherwise necessary.

Service Limitations

IES Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's Person-Centered Service Plan (PCSP).
- Support competitive integrated employment, customized employment, or self-employment outcomes.
- Be individualized and directly related to maintaining or advancing employment.

IES Services may not duplicate services available through:

- The Medicaid State Plan;
- EPSDT;
- Vocational Rehabilitation;
- Educational services;
- Other waiver services; or
- Any other formal or informal supports available to the participant.

Non-Covered Services

IES Services:

- May not duplicate services funded through Vocational Rehabilitation or educational programs.
- May not be provided solely for supervision unrelated to employment goals.
- May not be used to pay wages or employment-related expenses that are the responsibility of an employer.
- May not be provided when substantially similar services are available and being accessed through another funding source.

Billing or Service Code(s)

- The Individual Employment Support services are covered when rendered by the provider type and specialties, **55/581** (Career Exploration and Employment Support). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
H2023-U8, Initial	One 15-minute unit	55/581
H2025-U3, Ongoing	One 15-minute unit	55/581
H2025-U8, Maintenance	One 15-minute unit	55/581

Individual Employment Support services are not subject to the EVV requirements.

Note: IES may be authorized and billed for each hour the participant has been paid for work performed on the job. This methodology is intended to incentivize outcomes that include an increase in the number of hours the participant works, job coach fading, and the development of natural supports.

Provider Qualifications and Enrollment Requirements – Individual Employment Support

Individual Employment Support Services may be provided by:

- Employment Support Professional or Employment Support Agency – **55/581**

Employment Support Professional

- Qualifications:
  - An Employment Support Professional must:
    - Maintain an industry-recognized employment support certification, including one of the following:
      - Association of People Supporting Employment First (APSE) Credentialed Employment Support Professional (CESP) certification;
      - Association of Community Rehabilitation Educators (ACRE) Employment Services Basic Certification;
      - ACRE Employment Services Professional Certification;
      - ACRE Customized Employment Basic Certification; or
      - ACRE Customized Employment Professional Certification.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
- Complete annual KDADS-approved training covering:
  - Restraint;
  - Restrictive interventions;
  - Crisis prevention, including positive behavioral supports; and
  - Crisis intervention, as specified in the CSW, Appendix G-2.

Employment Support Professional continued

- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **581** (Career Exploration and Employment Support using taxonomy 2865C1500X [Community Health]).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of APSE/CESP/ACRE certification
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Employment Support Agency

- Qualifications:
  - An Employment Support Agency must:
    - Employ staff providing Individual Employment Support (IES) services who maintain an industry-recognized employment support certification, including one of the following:
      - Association of People Supporting Employment First (APSE) Credentialed Employment Support Professional (CESP) certification;
      - Association of Community Rehabilitation Educators (ACRE) Employment Services Basic Certification;
      - ACRE Employment Services Professional Certification;
      - ACRE Customized Employment Basic Certification; or
      - ACRE Customized Employment Professional Certification.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Ensure all staff delivering direct services and supports:
      - Are authorized to work in the United States;
      - Meet all applicable employment standards established by the employing agency; and
      - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
        - Abuse, neglect, and exploitation prevention;
        - State law reporting requirements related to abuse, neglect, and exploitation;
        - Cardiopulmonary Resuscitation (CPR); and
        - Basic First Aid.
    - Ensure staff complete annual KDADS-approved training covering:
      - Restraint;
      - Restrictive interventions;
      - Crisis prevention, including positive behavioral supports; and
      - Crisis intervention, as specified in the CSW, Appendix G-2.

Employment Support Agency continued

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency Provider under provider specialty **581** (Career Exploration and Employment Support using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of APSE/CESP/ACRE certification
    - Attestation: IES Staff Certification
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

LIFE SKILLS

Service Definition

Life Skill Services are designed to help participants develop the knowledge, skills, and abilities necessary to successfully transition to and navigate adulthood, while promoting independence, self-determination, and community inclusion. Services are individualized and focused on helping participants achieve and maintain their preferred lifestyle through skill development, education, coaching, and practical application of learned skills.

Life Skill Services support participants in developing skills across multiple life domains, including:

I. **Communication:** Effective communication skills for self-advocacy, active listening, and public speaking, including adaptive and assistive technology supported communication
II. **Personal Development:** Effective interpersonal skills, intimate relationship management, anger management, stress management, conflict resolution and self-esteem
III. **Problem-solving and Time Management:** Identifying and addressing challenges, thinking critically, making informed decisions, setting priorities and prioritizing tasks, goal tracking, managing deadlines, and organizing personal tasks and responsibilities
IV. **Adaptability:** Flexibility, resilience, and the ability to adjust to change
V. **Technical Skills:** Proficiency in relevant computer software, tools, and technology (e.g., Microsoft Office, email, basic IT skills, using an ATM, etc.)
VI. **Financial Management:** Money management, credit building, bill payment, budgeting, and saving
VII. **Independent Living Skills:** Personal property ownership, housing (renting, leasing), living with roommates, managing utilities, instruction in cooking, cleaning, home maintenance, or obtaining a driver's license
VIII. **Health and Wellness:** Navigating the health care system, scheduling medical appointments, personal hygiene, nutrition and exercise education, and mental health awareness
IX. **Transition and Future Planning:** Supporting participants in making successful transitions throughout their lives. This covers broad life transitions, such as moving into one's own residence, exploring post-secondary education, handling personal responsibilities, and engaging in the community.
X. **Digital and Technical Literacy:** Basic computer operation, internet safety, use of common software tools (e.g., Microsoft Office, email), and accessing virtual services.

Covered Services

Life Skill Services may be provided:

- Individually or in a group setting.
- At a provider's place of business.
- In community-based settings.
- Through in-person or virtual service delivery.

Providers offering virtual services must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Transportation provided as part of Life Skill Service activities is included in the service rate. Transportation between the participant's residence and the service location, or transportation unrelated to approved Life Skill Service activities, is not covered under this service.

Service Limitations

Life Skill Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's Person-Centered Service Plan (PCSP).
- Promote skill development and increased independence.
- Support community integration and successful adult living.

Life Skill Services may not duplicate services available through:

- The Medicaid State Plan;
- EPSDT;
- Vocational Rehabilitation;
- Educational services;
- Other waiver services; or
- Any other formal or informal supports available to the participant.

Non-Covered Services

Life Skill Services:

- May not be billed simultaneously with another waiver service when the activities are duplicative in nature.
- May not be provided as part of, within the scope of, or concurrently with another waiver service for the same purpose.
- Do not include transportation between the participant's home and the service location.

Billing or Service Code(s)

- The Life Skills services are covered when rendered by the provider type and specialties, **55/582** (Life Skills Support-CIL) or **55/583** (Life Skills Support-CSP). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
H2014-U3, Individual	One 15-minute unit	55/582, 55/583
H2014-U8, Group	One 15-minute unit	55/582, 55/583

Life Skills Support services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Life Skills Support

Life Skills Support Services may be provided by:

- Center for Independent Living (CIL) – **55/582**
- Community Support Provider (CSP) – **55/583**
- Life Skills Peer Provider (self-directed) – **55/530**

Center for Independent Living (CIL)

- Qualifications:
  - A Center for Independent Living (CIL) must:
    - Receive state or federal grant funding for independent living services as authorized under the Rehabilitation Act of 1973, as amended.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain a current certificate of worker's compensation insurance.
    - Maintain a current general liability insurance policy.
  - The CIL should ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The CIL should ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **582** (Life Skills Support using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CIL
    - Proof of CDDO Affiliation
    - Proof of Worker's Compensation Certificate
    - Proof of General Liability Insurance
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Community Support Provider (CSP)

- Qualifications:
  - A Community Support Provider (CSP) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Ensure staff delivering direct services and supports:
      - Are authorized to work in the United States.
      - Meet all applicable employment standards established by the employing agency.
      - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
        - Abuse, neglect, and exploitation prevention;
        - State law reporting requirements related to abuse, neglect, and exploitation;
        - Cardiopulmonary Resuscitation (CPR); and
        - Basic First Aid.
    - Ensure staff complete annual KDADS-approved training covering:
      - Restraint;
      - Restrictive interventions;
      - Crisis prevention, including positive behavioral supports; and
      - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **583** (Life Skills Support-Community Support Provider using taxonomy 2865C1500X [Community Health]).
  - Required attachments are:
    - W9
    - Proof of CSP License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Life Skills Peer Provider (Self-directed)

- Qualifications:
  - A Community Support Provider (CSP) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Ensure staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
    - Ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Individual Life Skills Peer Providers are not required to enroll as providers in KMMS/KMAP; however, they must have a valid provider agreement with the participant's FMS entity before delivering and billing for self-directed Life Skills services.

MEDICATION REMINDERS

Service Definition

Medication Reminder Services provide scheduled reminders to participants when it is time to take prescribed medications. The service is designed to promote medication adherence, support participant independence, and reduce the risk of missed doses that could negatively impact the participant's health and well-being.

Medication reminders may be provided through:

- Telephone calls;
- Automated recordings;
- Automated alarms; or
- Other approved reminder technologies utilized by the provider.

Medication Reminder Services are intended to support, but not replace, medication management performed by healthcare providers, caregivers, or the participant.

Covered Services

Medication Reminder Services may include:

- Medication Reminder Notifications
  - Scheduled reminders when medications are due.
  - Automated or provider-initiated notifications based on the participant's medication schedule.
  - Customization of reminder schedules to meet participant needs.
- Medication Reminder Dispenser Rental
  - Rental of a Medication Reminder Dispenser.
  - Programming and configuration of the dispenser to align with the participant's medication schedule.
  - Ongoing support related to the operation of the dispenser.
- Installation and Setup
  - Delivery and installation of approved Medication Reminder Dispensers in the participant's home.
  - Initial configuration and testing of the equipment.
  - Participant and caregiver orientation on equipment use.
- Participant Education and Support
  - Education regarding proper use of reminder systems and equipment.
  - Assistance during implementation and setup.
  - Ongoing support as needed to ensure the participant can effectively use the service.

Medication Reminder Services are generally provided through remote technology and are not face-to-face services, except when necessary for:

- Installation of a Medication Reminder Dispenser;
- Initial participant training; or
- Equipment troubleshooting and support.

Medication Reminder Dispensers are devices that store medications and provide scheduled alerts while dispensing medications at pre-programmed times.

Providers are responsible for ensuring participants and caregivers receive adequate instruction and support related to the use of the reminder system.

Service Limitations

Personal Medication Reminder Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's Person-Centered Service Plan (PCSP).
- Support participant independence and medication adherence.
- Be directly related to the participant's need for medication reminders and support.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports.

Equipment and Maintenance Requirements

Medication Reminder Services include:

- Equipment rental;
- Equipment installation; and
- Routine maintenance of rented equipment.

Medication Reminder Services do not include:

- Purchase of equipment;
- Replacement of equipment; or
- Repair of participant-owned equipment.

Maintenance and repair of rented equipment remain the responsibility of the provider.

Temporary Institutional Stays

Medication Reminder Systems may remain on a monthly rental basis when a participant is temporarily admitted to a nursing facility or an acute care facility, for a period not exceeding two months following the month of admission, in accordance with Medicaid policy.

Non-Covered Services

Medicaid Reminder services:

- Do not include medication administration.
- Do not include medication management performed by licensed healthcare professionals.
- Do not include dispensing, prescribing, or monitoring medications for therapeutic purposes.
- Do not include the purchase, replacement, or repair of equipment beyond rental services.

Billing or Service Code(s)

- The Medication Reminder services are covered when rendered by the provider type and specialty, **55/589** (Medication Reminder Services). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T1505-U3, Installation	One install	55/589
T1505-U8, Rental	One month	55/589
S5185-U8, Reminder Call	One month	55/589

EVV is optional for Medication Reminder Services. Providers choosing to utilize EVV must comply with all applicable EVV requirements and documentation standards.

Provider Qualifications and Enrollment Requirements – Medication Reminders

Medication Reminder services may be provided by:

- Medication Reminder Services Provider – **55/589**

Medication Reminder Services Provider

- Qualifications:
  - A Medication Reminder Services Provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Operate in accordance with recognized industry standards applicable to medication reminder systems, medication dispensing technologies, and medication management support services.
    - Provide appropriate training to staff responsible for medication reminder services, including the operation of medication reminder systems and medication dispensing devices.
  - The Medication Reminder Services Provider shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Medication Reminder Services Provider shall ensure that staff possess the knowledge and competency necessary to:
    - Install and configure Medication Reminder Dispensers and related equipment.
    - Educate participants and caregivers regarding the proper use of medication reminder systems.
    - Provide ongoing technical assistance and support.
    - Ensure medication reminder services are delivered consistently with the participant's PCSP.

Medication Reminder Services Provider continued

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **589** (Medication Reminder Services using taxonomy 101YP1600X).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

NON-MEDICAL TRANSPORTATION (NMT)

Service Definition

Non-Medical Transportation services provide transportation that enables participants to access waiver services, community services, activities, and resources identified in the participant's PCSP. The service is intended to support community integration, independence, and participation in activities that promote the participant's goals and desired outcomes.

NMT is available only when transportation is not otherwise available through another waiver service, the Medicaid State Plan, EPSDT, Vocational Rehabilitation, the educational system, or any other formal or informal support.

Targeted Case Managers (TCMs) and MCO Care Coordinators must document that alternative transportation resources are unavailable or unable to meet the participant's transportation needs prior to authorizing NMT.

Covered Services

Non-Medical Transportation Services may include:

- Transportation to Waiver Services:
  - Transportation necessary to access authorized waiver services identified in the participant's PCSP when transportation is not included within the authorized service.
  - Transportation may be provided to support access to waiver services that promote community participation, independence, employment, and other service-specific goals.
- Transportation to Community Services, Activities, and Resources: Transportation may be provided to access community activities, services, and resources when:
  - The activity is directly connected to goals and outcomes identified in the participant's PCSP.
  - The activity promotes participation in community life and integration into the greater community.
  - The activity increases opportunities for employment, community engagement, control of personal resources, or access to community services available to individuals not receiving HCBS services.
  - The activity supports development of relationships and connections within the community.
- Transportation through Qualified Providers: NMT may be delivered through:
  - Qualified Non-Medical Transportation providers;
  - Transportation brokers; or
  - Public transportation systems through the purchase of transit passes, tickets, or other approved transportation supports.

Non-Medical Transportation providers shall:

- Transport participants using the most direct and efficient route reasonably available.
- Provide transportation in a manner that promotes participant health, safety, dignity, and community inclusion.
- Coordinate transportation according to the participant's authorized service needs and schedule.
- Comply with all applicable state and federal transportation requirements.

NMT does not include training participants on how to use or navigate public transportation systems.

Community Participation Requirements

When NMT is used to access community services, activities, or resources, the activity must:

- Be directly related to goals identified in the participant's PCSP.
- Promote full access to the greater community consistent with the HCBS Settings Final Rule.
- Support opportunities for community participation, competitive integrated employment, community relationships, and personal independence.
- Not be limited solely to activities organized by provider agencies for groups consisting only of individuals with disabilities.

Activities should encourage interaction with community members and resources not connected exclusively to Medicaid-funded services.

Service Authorization Requirements

Requests for Non-Medical Transportation must be supported by documentation demonstrating:

- A transportation need exists.
- Alternative transportation options are unavailable or insufficient.
- The transportation supports goals identified in the participant's PCSP.
- The service is cost-effective and appropriate for the participant's needs.

Targeted Case Managers shall submit transportation documentation, including transportation requests and supporting information, to the Managed Care Organization for review and authorization.

Service Limitations

Non-Medical Transportation Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Support access to identified services, activities, resources, or goals.
- Be the most cost-effective transportation option that meets the participant's needs.
- NMT may not duplicate transportation available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - Educational programs;
  - Other waiver services;
  - Publicly available transportation resources; or
  - Any other formal or informal support available to the participant.

Whenever available and appropriate, transportation provided by family members, friends, neighbors, community organizations, or other unpaid resources should be utilized before authorizing waiver-funded transportation.

Non-Covered Services

Non-Medical Transportation Services:

- Do not include transportation training.
- Do not include transportation that is already included within another authorized waiver service.
- Do not include transportation available through another funding source or program.
- Do not cover transportation unrelated to goals identified in the participant's PCSP.
- Do not include recreational transportation that does not support an identified service plan outcome.

Operational Requirements

Non-Medical Transportation Providers shall:

- Communicate estimated arrival times to participants.
- Notify participants promptly when delays occur.
- Ensure return trips are completed using efficient routes without unnecessary delays.
- Maintain appropriate transportation records and service documentation.
- Comply with applicable KDADS, KDHE, and KMAP transportation requirements.

Billing or Service Code(s)

- The non-medical transportation services are covered when rendered by the provider type and specialties, **26/574** (NMT- Contracted Transportation Agency (CTA)) or **55/530** (Individual driver in agreement with FMS for self-directed services). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Agency-Directed NMT (Covered by 26/574)

Code-Modifier	Service Type	Unit Definition
A0080-U1	Single	Per mile
A0110-U8	Single (public or private bus, intra or inter-state carrier)	Per trip
T2004-U8	Single (commercial carrier, multi-pass)	Per trip
A0130-U1	Single, modified	Mileage or public fare
A0080-U3	Group 2-3	Mileage or public fare
A0130-U3	Group 2-3, modified	Mileage or public fare
A0080-U8	Group 4+	Mileage or public fare
A0130-U8	Group 4+, modified	Mileage or public fare

NMT services are not subject to the EVV requirements.

Billing or Service Code(s) continued

Self-Directed NMT (Covered when billed by 55/530)

Code-Modifier	Service Type	Unit Definition
A0080-U6	Single	Per mile
A0110-U6	Single (public or private bus, intra or inter-state carrier)	Per trip
T2004-U6	Single (commercial carrier, multi-pass)	Per trip
A0130-U6	Single, modified	Mileage or public fare
A0080-U9	Group 2-3	Mileage or public fare
A0130-U9	Group 2-3, modified	Mileage or public fare
A0080-UA	Group 4+	Mileage or public fare
A0130-UA	Group 4+, modified	Mileage or public fare

NMT services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – NMT

Non-medical transportation services may be provided by:

- Contracted Transportation Agency (CTA) – **26/574**
- Individual Driver via FMS – **55/530**

Contracted Transportation Agency (CTA)

- Qualifications:
  - A Contracted Transportation Agency must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Be enrolled with KMAP, when required, and maintain all applicable provider enrollment requirements.
    - Comply with all applicable federal, state, and local laws, regulations, and requirements governing transportation services.
  - The Contracted Transportation Agency shall:
    - Adhere to the provider participation standards and operational requirements applicable to Non-Emergency Medical Transportation (NEMT) providers as outlined in the KDHE KanCare NEMT Policy and the **NEMT Provider Manual**.
    - Ensure transportation services are delivered safely, reliably, and in accordance with participant needs identified in the PCSP.
    - Maintain policies and procedures consistent with KDADS and KDHE transportation requirements.
  - The Contracted Transportation Agency shall ensure that drivers:
    - Meet all applicable driver qualification standards established by KDHE, KDADS, and applicable transportation regulations.
    - Maintain a valid driver's license appropriate for the vehicle operated.
    - Meet applicable background screening requirements.
    - Maintain required vehicle insurance, registration, inspections, and safety standards.
    - Operate vehicles in compliance with all state and federal transportation laws and regulations.

Contracted Transportation Agency (CTA) continued

- The Contracted Transportation Agency shall ensure staff and drivers possess the knowledge, skills, and competencies necessary to:
  - Safely transport participants to authorized destinations.
  - Assist participants as appropriate during transport activities.
  - Respond appropriately to participant health, safety, or emergency situations.
  - Protect participant rights, dignity, confidentiality, and safety during service delivery.

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **574** (NMT-Contracted Transportation Agency using taxonomy 224ZR0403X).
    Note: **Provider must enroll under the existing transportation provider type 26 (Transportation Provider).**
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Vehicle Registration
    - Insurance Coverage
    - Copy of Business License
    - Driver Attestation showing ability to drive
    - Legible Driver's License for all drivers (Owner included)
    - Copies of Driver's License for all drivers copy
    - Copy of MVR (Annually)
    - NMT Provider Application
    - Proof of automobile insurance for each vehicle
    - Attestation: NMT Policy Compliance
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Individual Driver (via FMS)

- Qualifications:
  - An Individual NMT provider hired by a participant who elects to self-direct services must:
    - Enter into an employment or provider agreement with the FMS entity authorized to support self-directed services.
    - Meet all requirements established under the participant-directed service model and applicable federal and state laws and regulations.
  - An Individual NMT Provider must:
    - Be at least 18 years of age.
    - Possess a current, valid driver's license appropriate for the vehicle being operated.
    - Maintain proof of current vehicle insurance as required by state law.
    - Maintain current vehicle registration.
    - Maintain documentation of any state-required vehicle inspections, when applicable.

Individual Driver (via FMS) continued

- The Individual NMT Provider shall:
  - Operate vehicles in accordance with all applicable traffic, safety, insurance, and transportation laws.
  - Ensure transportation services are delivered safely and in a manner that protects participant health, safety, and welfare.
  - Use the most direct and appropriate route to transport participants to authorized destinations.
  - Maintain a safe, reliable, and properly maintained vehicle used for transportation services.
- Participant Responsibilities
  - Participants who self-direct NMT services are responsible for:
    - Selecting and employing qualified transportation providers.
    - Verifying that the transportation provider meets program requirements.
    - Ensuring the transportation provider maintains all required licensing, insurance, registration, and inspection documentation.
    - Monitoring service quality and ensuring transportation services are delivered in accordance with the participant's PCSP.

- KMMS Enrollment:
  - Individual NMT drivers are not required to enroll as providers in KMMS/KMAP; however, they must have a valid provider agreement with the participant's FMS entity before delivering and billing for self-directed transportation services.

PERSONAL CARE SERVICES (AGENCY-DIRECTED)

Service Definition

Personal Care Services (PCS) are individualized supports that enable participants to perform tasks they would normally complete independently if not for the limitations associated with their disability. PCS are provided on a one-to-one basis and may be delivered as ongoing or intermittent assistance during times when the participant is awake.

Services may be delivered through hands-on assistance, supervision, cueing, prompting, or other supports necessary to help the participant safely complete daily activities and maintain independence in home and community settings.

Covered Services

PCS may include assistance with the following activities:

- **Activities of Daily Living (ADLs):** Assistance with Activities of Daily Living as defined in K.A.R. 30-5-300, including:
  - Bathing
  - Dressing
  - Toileting
  - Transferring
  - Ambulating
  - Eating
- **Health Maintenance Activities (HMAs):** Health Maintenance Activities performed in accordance with KDADS Personal Care Services policies and delegated by a physician or licensed nurse, including:
  - Monitoring vital signs
  - Supervision and training of nursing procedures
  - Ostomy care
  - Catheter care
  - Enteral nutrition
  - Wound care
  - Range-of-motion activities
  - Reporting changes in condition or functioning
  - Medication administration and medication assistance
- **Instrumental Activities of Daily Living (IADLs):** Assistance with Instrumental Activities of Daily Living as defined in K.A.R. 30-5-300, including:
  - Meal preparation
  - Shopping
  - Medication monitoring and treatments
  - Laundry and housekeeping
  - Money management
  - Communication
  - Transportation
- **Supervision:** Monitoring the participant's safety, health, and well-being when supervision is necessary to support continued community living (non-foster care participants only).
- Community Participation and Social Engagement: Assistance and accompaniment for:
  - Exercise and wellness activities
  - Recreational activities
  - Socialization opportunities
  - Community participation

Covered Services continued

- **Access to Medical Care:** Support necessary to access healthcare services, including:
  - Transportation accompaniment related to medical care
  - Assistance during medical appointments
  - Assistance during therapeutic appointments when identified in the participant's PCSP.

Personal Care Services may be delivered in any of the following settings:

- The participant's home;
- Community settings that comply with the HCBS Settings Final Rule;
- Higher education settings;
- Employment settings; and
- Hospital settings when necessary to support Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

PCS provided in educational environments must not be educational in nature.

PCS provided in employment settings must address disability-related support needs identified in the PCSP and may not duplicate services provided through Individual Employment Support Services or other employment-related programs.

PCS provided in a hospital setting may support activities such as ADLs and IADLs but may not duplicate services that are the responsibility of the hospital.

Participant Direction

Participants or their designated representatives may choose to self-direct Personal Care Services. Participants who self-direct services are responsible for:

- Recruiting, hiring, training, supervising, and dismissing PCS workers;
- Complying with applicable federal and state employment requirements;
- Ensuring services are delivered according to the participant's PCSP; and
- Maintaining required service documentation.

PCS workers employed by the participant must receive participant-specific training using a PCS training checklist developed by the participant or representative, with assistance from the Care Coordinator when needed.

The PCS training checklist shall:

- Be maintained in the participant's home;
- Be incorporated into the participant's PCSP;
- Be reviewed at least annually; and
- Be updated whenever service needs change.

Participants receiving services in licensed foster care settings may not self-direct services unless they meet established exception criteria.

Participants may transition between self-directed and provider-managed PCS at any time in accordance with KDADS Personal Care Services policy.

Virtual Service Delivery

Participants receiving provider-managed PCS may choose in-person or virtual service delivery when authorized and appropriate.

Providers delivering PCS virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Service Limitations

Personal Care Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Support the participant's ability to live safely and independently in the community.
- Be provided only to the extent necessary to address disability-related needs.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports.

A participant may receive services from multiple PCS workers; however, no more than one PCS worker may provide services at the same time unless additional staffing is necessary to meet the participant's assessed needs and is authorized in the PCSP.

PCS may not be financially supplemented by the participant, family members, or other natural supports.

Non-Covered Services

Personal Care Services:

- May not duplicate services provided through another Medicaid-funded program.
- May not duplicate services delivered by hospitals, schools, employers, or other service systems.
- May not be provided solely for convenience or companionship when the activity does not address an assessed disability-related need.
- May not include services outside the scope of the participant's approved PCSP.

Billing or Service Code(s) – Agency-Directed

- The Agency-Directed Personal Care services are covered when rendered by the provider type and specialty, **55/584** (Personal Care Service-Home Health Agency). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
S5125-U8	One 15-minute unit	55/584

Personal Care services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – PCS (Agency-Directed)

Personal Care Services may be provided by:

- Home Health Agency (HHA) – **55/584**

Home Health Agency (HHA)

- Qualifications:
  - A Home Health Agency providing Personal Care Services (PCS) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain all licenses, certifications, and approvals required to operate as a Home Health Agency under applicable federal and state laws and regulations.
  - The Home Health Agency shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - Home Health Agency staff providing Personal Care Services must:
    - Be at least 18 years of age or possess a high school diploma or GED.
    - Demonstrate the knowledge, skills, and competencies necessary to safely provide services identified in the participant's Person-Centered Service Plan (PCSP).
  - The Home Health Agency shall ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention,
  - Health Maintenance Activity Requirements:
    - Certified Home Health Aides (CHHAs) and Certified Nurse Aides (CNAs):
      - Shall not perform Health Maintenance Activities (HMAs) unless those activities have been delegated by a licensed physician or nurse in accordance with K.S.A. 65-1165 and applicable state regulations.
      - Shall not perform tasks beyond the scope of their training, education, certification, or curriculum unless appropriately delegated and supervised by a licensed nurse.
  - The Home Health Agency must:
    - Maintain written documentation of all physician or nursing delegations.
    - Maintain documentation demonstrating appropriate supervision of delegated Health Maintenance Activities.
    - Ensure delegated services are performed in accordance with all applicable state statutes, regulations, professional practice standards, and KDADS policy requirements.
    - Comply with KDADS Personal Care Services and Limitations policy governing provider-managed service delivery.

Failure to appropriately supervise, direct, or delegate Health Maintenance Activities may result in professional disciplinary action under applicable state licensing requirements.

Home Health Agency (HHA) continued

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **584** (Home Telehealth Services (HHA) using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: PCS Delegation & Supervision
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

PERSONAL CARE SERVICES (SELF-DIRECTED)

Overview

The Self-Directed Personal Care service follows the same Service Definition, Covered Services, Participant Direction, Service Limitations, and Non-Covered Services outlined under the Personal Care Services (Agency-Directed) section. The only differences applicable to Self-Directed Personal Care Services are the provider enrollment requirements and billing/service codes identified below. Refer to the Agency-Directed Personal Care Services section for all other service requirements and coverage provisions, specifically section titled 'Participant Direction'.

Billing or Service Code(s) – Self-Directed

- The Self-Directed Personal Care services are covered when billed by the provider type and specialty, **55/530** (Financial Management Services). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T1019-U8	One 15-minute unit	55/530

Personal Care services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – PCS (Self-Directed)

Self-Directed Personal Care Services may be provided by:

- Personal Care Services (PCS) Worker via FMS – **55/530**

A Personal Care Services (PCS) worker hired by a participant who elects to self-direct services must:

- Enter into an employment or provider agreement with the Financial Management Services (FMS) entity authorized to support self-directed services.
- Meet all requirements established through the participant-directed service model and applicable federal and state employment regulations.

A self-directed PCS worker must:

- Be at least 16 years of age, or
- Be at least 18 years of age when the worker is a sibling of the participant, unless a written exception has been approved by the Long-Term Services and Supports Commission in accordance with K.A.R. 30-63-10(4)(F).

The PCS worker shall:

- Be authorized to work in the United States.
- Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
  - Abuse, neglect, and exploitation prevention;
  - State law reporting requirements related to abuse, neglect, and exploitation;
  - Cardiopulmonary Resuscitation (CPR); and
  - Basic First Aid.

Participant Training Responsibilities:
Consistent with K.A.R. 30-63-10, the participant or the participant's designated representative is responsible for ensuring that the PCS worker receives sufficient training to safely and effectively perform the tasks identified within the participant's PCSP.

The participant or representative shall:

- Develop and maintain participant-specific training instructions, as appropriate.
- Verify that the PCS worker has demonstrated competency in completing assigned tasks.
- Maintain documentation of training provided to the PCS worker.
- Provide documentation of completed training to the CDDO upon request.

Training must be individualized and reflect the participant's specific needs, preferences, health conditions, support requirements, and authorized service activities.

- KMMS Enrollment:
  - PCS workers are not required to enroll as providers in KMMS/KMAP; however, they must have a valid provider agreement with the participant's FMS entity before delivering and billing for self-directed personal care services.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Service Definition

Personal Emergency Response System Services provide participants with access to emergency assistance through the use of electronic devices that allow the participant to quickly summon help when an emergency occurs. The system is connected and programmed to signal a response center when activated, helping to support participant health, safety, and independence in the community.

PERS is intended to provide participants with immediate access to assistance during emergencies while promoting continued independent living in the least restrictive environment possible.

Covered Services

PERS Services may include:

- Personal Emergency Response System Equipment
  - Provision of a PERS device and associated monitoring services.
  - Continuous access to an emergency response system.
  - Connection to a response center that can initiate appropriate emergency response procedures.
  - Monitoring and support services related to operation of the system.
- PERS Installation
  - Delivery and installation of approved PERS equipment in the participant's residence.
  - Initial testing and configuration of the system.
  - Verification that the system is functioning properly at the time of installation.
- System Monitoring and Maintenance
  - Ongoing monitoring of the PERS system.
  - Routine maintenance of rented equipment.
  - Monthly system checks to ensure the system, backup batteries, and backup power sources remain functional and operational.

All PERS systems must:

- Be connected to a response center capable of responding to emergency signals.
- Include backup batteries or other backup power sources.
- Have documented emergency protocols in the event of system failure.
- Be tested at least monthly to ensure proper operation.

The provider must:

- Obtain participant consent for placement and use of the device within the participant's residence.
- Ensure participants retain control over the system and their living environment.
- Follow up with the participant whenever the system is intentionally turned off or disconnected to assess the participant's health and welfare.

Participants must have the ability to:

- Turn off or unplug the system when desired.
- Maintain control over the equipment within their residence.

If a participant turns off or disconnects the system, an alert shall be generated to the provider, and follow-up procedures shall be initiated.

Service Limitations

PERS Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Support participant health, safety, and independent community living.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports available to the participant.

Equipment and Maintenance Requirements

PERS Services include:

- Equipment rental;
- Equipment installation;
- Monitoring services; and
- Routine maintenance of rented equipment.

PERS Services do not include:

- Purchase of equipment;
- Repair of participant-owned equipment; or
- Replacement of equipment owned by the participant.

Maintenance of rented equipment is the responsibility of the provider.

Non-Covered Services

PERS Services:

- May not duplicate services available through another funding source.
- May not replace supervision, emergency medical services, or other direct care services identified in the participant's PCSP.
- Do not include equipment purchase or ownership by the participant.

Billing or Service Code(s)

- The PERS services are covered when rendered by the provider type and specialty, **55/579** (Personal Emergency Response Services). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
S5160-U8, Installation	One install	55/579
S5161-U8, Rental	One month	55/579

PERS services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – PERS

PERS services may be provided by:

- Personal Emergency Response System Services Provider – **55/579**

PERS Provider

- Qualifications:
  - A Personal Emergency Response System (PERS) Provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Conform to all applicable industry standards and comply with all federal, state, and local laws, regulations, and requirements governing Personal Emergency Response System services.
    - Operate and maintain a response system capable of receiving and responding to participant emergency alerts in a timely manner.
    - Maintain an emergency response center that is staffed 24 hours per day, 7 days per week by trained personnel capable of responding to participant emergency situations.
  - The PERS Provider shall ensure that:
    - Emergency response personnel receive appropriate training related to emergency response protocols, participant safety, and operation of the PERS system.
    - All PERS equipment, monitoring systems, and support services are maintained in good working order and function in accordance with manufacturer specifications and applicable safety standards.
    - Backup systems, emergency protocols, and contingency procedures are in place to ensure continuity of service during equipment failures, power outages, or other service interruptions.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **579** (PERS services using taxonomy 2865C1500X).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Attestation: 24/7 Operations & Standards Compliance
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

REMOTE SUPPORT

Service Definition

Remote Support Services use technology to provide monitoring, assistance, and support from a remote location in place of continuous in-person staff presence. The service enables participants to communicate with support staff in real time and receive assistance, guidance, or intervention when needed while promoting independence and community living.

Remote Support Services are designed to enhance participant independence while ensuring access to support when health, safety, or functional needs arise. Services may be provided in the participant's home or in community settings and are intended to supplement, not replace, supports identified in the participant's PCSP.

Covered Services

Remote Support Services may include:

- Real-Time Remote Assistance
  - On-demand communication between the participant and remote support staff.
  - Immediate response to participant requests for assistance.
  - Remote monitoring of participant well-being and support needs.
  - Coordination of follow-up supports when in-person assistance is required.
- Monitoring and Safety Supports: Remote Support Services may utilize technology such as:
  - Two-way communication systems;
  - Sensors and monitoring devices;
  - Global Positioning System (GPS) technology;
  - Webcams or video communication devices; and
  - Other approved remote monitoring technologies.
    - Technology must support the participant's assessed needs and enable communication or notification when assistance may be required.
- Support Planning and Coordination: The Remote Support Services provider shall:
  - Develop a Remote Support Plan based on the participant's PCSP.
  - Define the parameters of remote monitoring and support.
  - Identify individuals who may be contacted when in-person support is needed, including:
    - Family members;
    - Neighbors;
    - Natural supports; or
    - Other designated emergency contacts.

Remote Support Services may be provided:

- In the participant's residence;
- In community settings;
- Through real-time audio, video, or other approved communication technology.

Participants must have access to on-demand communication with remote support staff capable of responding to identified support needs.

Providers shall ensure Remote Support Services are delivered in a manner that promotes participant autonomy, dignity, privacy, and independence.

Participant Rights and Informed Consent

When Remote Support Services involve audio or video technology that allows remote staff to view activities or listen to conversations within the participant's residence, informed written consent is required.

Prior to implementation, the participant and all individuals residing in the residence must be informed of:

- The nature and purpose of the monitoring;
- Whether staff may observe activities or conversations;
- The location(s) within the residence where monitoring will occur; and
- Whether recordings will be created or retained.

Written consent must be obtained from:

- The participant;
- Any person residing in the residence subject to the monitoring; and
- The guardian, when applicable.

A copy of all signed consent forms must be maintained in the participant's PCSP.
Participants must retain the ability to:

- Turn monitoring equipment on or off;
- Control access to their living environment; and
- Withdraw consent in accordance with applicable policy requirements.

Bedroom and Bathroom Monitoring

The use of audio or video monitoring equipment in bedrooms or bathrooms is permitted only when:

- An assessment demonstrates that the technology increases independence while protecting the participant's privacy and dignity;
- The participant or guardian provides written consent;
- The participant's support team approves the use of the technology;
- The MCO approves the service; and
- The service is documented in the participant's PCSP.

The ongoing use of monitoring equipment in bedrooms or bathrooms must be reviewed during periodic PCSP reviews and include a plan to reduce or eliminate the monitoring when appropriate.

Service Limitations

Remote Support Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Promote participant independence, health, safety, and community integration.
- Be the least restrictive option appropriate to meet the participant's needs.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports available to the participant.

Equipment and Maintenance Requirements

Remote Support Services include:

- Equipment rental;
- Installation and configuration of approved equipment;
- Monitoring services; and
- Maintenance of rented equipment.

Remote Support Services do not include:

- Purchase of equipment;
- Repair of participant-owned equipment; or
- Replacement of participant-owned equipment.

Maintenance of rented equipment remains the responsibility of the provider.

Non-Covered Services

Remote Support Services:

- May not be used solely for staff convenience.
- May not restrict participant rights, privacy, or autonomy beyond what is approved through the PCSP and informed consent process.
- May not duplicate direct care or supervision services available through another waiver service or funding source.
- Do not include the purchase or ownership of monitoring equipment.

Billing or Service Code(s)

- The Remote Support services are covered when rendered by the provider type and specialty, **55/578** (Remote Support). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
99457-U8	First 20 mins each month	55/578
99458-U8	Each additional 20 mins	55/578

Remote Support services are not subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Remote Support

Remote Support services may be provided by:

- Remote Support Services Provider – **55/578**

Remote Support Services Provider

- Qualifications:
  - A Remote Support services provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Comply with all applicable federal, state, and local laws, regulations, and industry standards governing the delivery of Remote Support Services.
    - Maintain the technological infrastructure necessary to provide real-time remote monitoring, communication, and support consistent with the participant's PCSP.
    - Ensure remote monitoring and communication systems are secure, reliable, and capable of protecting participant privacy and confidentiality.
  - The Remote Support Services Provider must maintain a remote support center that:
    - Is staffed 24 hours per day, 7 days per week by trained personnel.
    - Has the capability to receive alerts and respond to participant needs in real time.
    - Maintains documented protocols for responding to participant emergencies, health and safety concerns, equipment failures, and service interruptions.
    - Has procedures in place to contact designated emergency contacts, natural supports, or emergency responders when in-person intervention is required.
  - The provider shall ensure staff responsible for Remote Support Services:
    - Are appropriately trained in the use of remote support technology and monitoring systems.
    - Understand participant rights related to privacy, consent, dignity, and self-determination.
    - Are trained in emergency response procedures and participant support protocols.
    - Maintain competency in operating the technology utilized for Remote Support Services.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **578** (Remote Support using taxonomy 2865C1500X).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Attestation: 24/7 Operations & Standards Compliance
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

RESPITE CARE (AGENCY-DIRECTED)

Service Definition

Respite Services provide temporary direct care and supervision to a participant when the participant's unpaid caregiver is unavailable or requires relief from caregiving responsibilities. The service is intended to support both the participant and the unpaid caregiver by ensuring the participant's health, safety, and support needs continue to be met during periods when the caregiver is unable to provide care.

Respite Services include assistance with activities that are also available under Personal Care Services, including Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Covered Services

Respite Services may be provided on a planned or emergency basis and may include support during the participant's awake or sleeping hours.

Services may be delivered in any of the following settings:

- The participant's home;
- The private residence of a relative, friend, or respite provider;
- A licensed respite care home or facility;
- A licensed foster home;
- A facility approved by KDHE or KDADS that is not a private residence; or
- Community settings outside the participant's home.

Participant Direction

Participants may self-direct Respite Services unless the participant is a child in the custody of the Kansas Department for Children and Families (DCF) who resides in a licensed foster care setting.

Service Limitations

Respite Services must:

- Be based on the participant's assessed needs and authorized through the participant's PCSP.
- Support needs that cannot be met through unpaid caregivers or other available resources.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports.

Non-Covered Services

Respite Services:

- May not be provided simultaneously with Personal Care Services.
- May not be provided by a parent when the participant is a minor child.
- May not be provided to an individual who is an inpatient of a hospital or State Mental Hospital when the facility is billing Medicaid, Medicare, or private insurance for the inpatient stay.

Billing or Service Code(s) – Agency-Directed

- The Agency-Directed Respite Care services are covered when rendered by the provider type and specialties, **55/585** (Respite Care-CMHC) or **55/586** (Respite Care-CSP). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T1005-U1, Individual	One 15-minute unit	55/585, 55/586
T1005-U2, Group	One 15-minute unit	55/585, 55/586

Respite Care services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Respite Care (Agency-Directed)

Respite Care Services may be provided by:

- Community Mental Health Center (CMHC) – **55/585**
- Community Support Provider (CSP) – **55/586**

Community Mental Health Center (CMHC)

- Qualifications:
  - A Community Mental Health Center (CMHC) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain all applicable state licenses, certifications, and approvals required to operate as a Community Mental Health Center in Kansas.
  - The CMHC shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The CMHC shall ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **585** (Respite Care-CMHC using taxonomy 261QM0801X (Community Mental Health Center)).
  - Required attachments are:
    - W9
    - Proof of CMHC License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

Community Support Provider (CSP)

- Qualifications:
  - A Community Service Provider (CSP) must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain all applicable licenses, certifications, approvals, and operational requirements necessary to provide community-based services in accordance with state and federal requirements.
  - The CSP shall ensure that staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The CSP shall ensure staff complete annual KDADS-approved training covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention, as specified in the CSW, Appendix G-2.
  - The CSP shall ensure staff possess the knowledge, skills, and competencies necessary to provide services in accordance with the participant's PCSP, support participant health and safety, and promote independence, community integration, and self-determination.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **586** (Respite Care-Community Support Provider using taxonomy 2865C1500X (Community Health)).
  - Required attachments are:
    - W9
    - Proof of CSP License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - Section 12 Attestation / Consent and Release Form
  - Must maintain an active provider enrollment record.

RESPITE CARE (SELF-DIRECTED)

Overview

The Self-Directed Respite Care service follows the same Service Definition, Covered Services, Participant Direction, Service Limitations, and Non-Covered Services outlined under the Respite Care (Agency-Directed) section. The only differences applicable to Self-Directed Respite Care are the provider enrollment requirements and billing/service codes identified below. Refer to the Agency-Directed Respite Care section for all other service requirements and coverage provisions.

Participant Direction

Participants may self-direct Respite Services unless the participant is a child in the custody of the Kansas Department for Children and Families (DCF) who resides in a licensed foster care setting.

Billing or Service Code(s) – Self-Directed

- The Self-Directed Respite Care services are covered when billed by the provider type and specialty, **55/530** (Financial Management Services). The providers must enroll under the listed specialty to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
T1005-U3, Individual	One 15-minute unit	55/530
T1005-U8, Group	One 15-minute unit	55/530

Respite Care services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – Respite Care (Self-Directed)

Self-Directed Respite Care Services may be provided by:

- Respite Provider via FMS – **55/530**
  - A Respite Provider hired by a participant who elects to self-direct services must:
    - Enter into an employment or provider agreement with the FMS entity authorized to support self-directed services.
    - Meet all requirements established under the participant-directed service model and applicable federal and state employment regulations.
  - A self-directed Respite Provider must:
    - Be at least 18 years of age.
    - Reside outside of the participant's home.
    - Complete all KDADS-required training applicable to the provision of Respite Services.
    - Meet any additional qualifications established by the participant or the participant's designated representative.

The Respite Provider shall:

- Be authorized to work in the United States.
- Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
  - Abuse, neglect, and exploitation prevention;
  - State law reporting requirements related to abuse, neglect, and exploitation;
  - Cardiopulmonary Resuscitation (CPR); and
  - Basic First Aid.

Participant Responsibilities:
Participants who self-direct Respite Services are responsible for:

- Recruiting, selecting, training, supervising, and dismissing respite providers.
- Establishing any additional provider qualifications necessary to meet the participant's needs.
- Ensuring the respite provider is capable of safely performing the tasks identified in the participant's PCSP.
- Maintaining documentation supporting provider training and competency, as required.

Participants may establish additional qualifications, training requirements, or experience standards beyond the minimum program requirements when necessary to support their individual needs and preferences.

- KMMS Enrollment:
  - Respite providers are not required to enroll as providers in KMMS/KMAP; however, they must have a valid provider agreement with the participant's FMS entity before delivering and billing for self-directed respite care services.

THERAPY SERVICES

BEHAVIOR THERAPY

Service Definition

Behavior Therapy services utilize evidence-based behavioral principles and interventions to help participants develop new skills, reduce challenging behaviors, and improve their ability to function successfully in home, work, and community settings. The service focuses on understanding how behaviors are learned and maintained and applying research-based strategies that increase independence, improve quality of life, and promote successful community living.

Behavior Therapy is individualized and may address behavioral, emotional, social, communication, and adaptive functioning needs. While therapy may consider historical experiences and contributing factors, the primary focus is on improving the participant's current environment, strengthening self-regulation skills, increasing independence, and developing effective ways to meet personal needs and goals.

Covered Services

Behavior Therapy Services may include the following activities:

- **Behavioral Assessments**: Behavior Therapy may include comprehensive behavioral evaluations to identify factors that influence behavior and to guide the development of effective intervention strategies.
- Functional Behavior Assessments (FBAs) may be conducted to:
  - Identify the underlying causes or functions of challenging behaviors.
  - Analyze antecedents, behaviors, and consequences.
  - Determine environmental factors that contribute to behavior patterns.
- Preference Assessments may be conducted to:
  - Identify motivating factors and reinforcers.
  - Support the development of individualized interventions and skill-building activities.
  - Increase participant engagement and success.
- Behavioral Observation and Analysis
  - Observation and collection of behavioral data across settings and activities.
  - Identification of behavioral patterns and environmental influences.
  - Ongoing evaluation of intervention effectiveness.
- Behavior Intervention Planning
  - Development and implementation of individualized Behavior Intervention Plans (BIPs) designed to address identified needs and support positive outcomes.
- Behavior Intervention Plans may include:
  - Skill Acquisition: Teaching replacement skills that help participants meet their needs in more effective and socially appropriate ways, including:
    - Communication skills
    - Social skills
    - Emotional regulation skills
    - Coping strategies
    - Self-advocacy skills
    - Independent living and adaptive skills
  - Behavior Reduction Strategies: Implementing evidence-based interventions to reduce behaviors that interfere with health, safety, independence, employment, or community participation, including:
    - Aggressive behaviors
    - Self-injurious behaviors
    - Disruptive behaviors
    - Other maladaptive behaviors

Covered Services continued

- Behavior reduction strategies may include:
  - Differential reinforcement
  - Functional communication training
  - Environmental modifications
  - Positive behavior supports
  - Other evidence-based behavioral interventions
- Crisis Prevention and Management: Developing strategies to safely address high-risk behaviors and prevent behavioral crises. Activities may include:
  - Crisis prevention planning
  - Risk mitigation strategies
  - Behavioral stabilization techniques
  - Emergency response planning
- Workplace Behavior Management: Supporting participants in maintaining successful employment by addressing workplace-related behavioral concerns such as:
  - Motivation and engagement
  - Attendance and reliability
  - Communication with supervisors and coworkers
  - Workplace social interactions
  - Behavioral barriers affecting job retention or advancement

Behavior Therapy Services may be provided:

- Individually;
- In the participant's home;
- At a provider's place of business;
- In community-based settings; or
- In workplace settings when related to employment supports.

Participants may choose:

- In-person service delivery; or
- Virtual service delivery.
-

Providers delivering services virtually must comply with the requirements established in the KDADS Virtual Delivery of Services (VDS) policy.

Service Limitations

Behavior Therapy Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Be designed to improve adaptive functioning, increase independence, and reduce behaviors that interfere with community living.
- Utilize evidence-based behavioral interventions and supports.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - The educational system; or
  - Other formal or informal supports available to the participant.

Non-Covered Services

Behavior Therapy Services:

- May not duplicate behavioral health, therapy, counseling, or treatment services funded through another Medicaid program or funding source.
- May not be provided solely for participant supervision.
- May not include services unrelated to identified behavioral goals or objectives contained within the PCSP.

Billing or Service Code(s)

- The Behavior Therapy (BT) services are covered when rendered by the provider type and specialties, **55/590** (BT-Home Health Agency), **55/591** (BT- Registered Behavioral Technician), **55/592** (BT-Behavior Therapy Provider), **55/593** (BT- Licensed Psychologist), **55/594** (BT-Licensed Social Worker) or **55/595** (BT- Certified Behavior Analyst). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
H0004-U8	Each 15-minute	55/590, 591, 592, 593, 594, 595

Behavior Therapy services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – BT

Behavior therapy services may be provided by:

- Home Health Agency (HHA) – **55/590**
- Registered Behavioral Technician (RBT) – **55/591**
- Behavior Therapy (BT) Provider – **55/592**
- Licensed Psychologist (LP) – **55/593**
- Licensed Social Worker (LSW) – **55/594**
- Certified Behavior Analyst (CBA) – **55/595**

Home Health Agency (HHA)

- Qualifications:
  - A Home Health Agency (HHA) providing Behavior Therapy services must:
    - Be licensed and operated in accordance with K.S.A. 65-5101 et seq. and K.A.R. 28-51-100 et seq.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Home Health Agency shall ensure that licensed professionals providing Behavior Therapy services maintain the appropriate credentials required under Kansas law:
    - **Psychologists:** Psychologists employed by the Home Health Agency must:
      - Hold an active license issued by the Kansas Behavioral Sciences Regulatory Board (BSRB) in accordance with K.S.A. 74-5301 et seq.
    - **Social Workers:** Social Workers employed by the Home Health Agency must:
      - Hold an active license issued by the Kansas Behavioral Sciences Regulatory Board (BSRB) in accordance with K.S.A. 65-6301 et seq. as either:
  - A Licensed Master Social Worker (LMSW); or
  - A Licensed Specialist Clinical Social Worker (LSCSW),
    - **Registered Behavior Technicians (RBTs):** Registered Behavior Technicians providing Behavior Therapy services must:

Home Health Agency (HHA) continued

- Maintain a current Registered Behavior Technician (RBT) certification.
- Practice within the scope of their certification and under appropriate supervision, as required by certification standards and applicable regulations.
  - **Certified Behavior Analysts:** Certified Behavior Analysts providing Behavior Therapy services must maintain one of the following credentials:
- Board-Certified Behavior Analyst (BCBA);
- Board-Certified Behavior Analyst – Doctoral (BCBA-D); or
- Board-Certified Assistant Behavior Analyst (BCABA).
  - The Home Health Agency shall ensure that all staff delivering direct services and supports:
- Are authorized to work in the United States.
- Meet all applicable employment standards established by the employing agency.
- Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
  - Abuse, neglect, and exploitation prevention;
  - State law reporting requirements related to abuse, neglect, and exploitation;
  - Cardiopulmonary Resuscitation (CPR); and
  - Basic First Aid.
- The Home Health Agency shall ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
  - Restraint;
  - Restrictive interventions;
  - Crisis prevention, including positive behavioral supports; and
  - Crisis intervention,
- The Home Health Agency shall ensure staff possess the knowledge, skills, and competencies necessary to:
  - Conduct behavioral assessments and observations;
  - Develop and implement Behavior Intervention Plans (BIPs);
  - Provide skill acquisition and behavior reduction interventions;
  - Deliver crisis prevention and behavioral support strategies; and
  - Support participants in home, employment, and community settings consistent with the participant's PCSP.

- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **590** (BT-Home Health Agency using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Therapy Provider Licensure
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Registered Behavioral Technician (RBT)

- Qualifications:
  - A Registered Behavior Technician (RBT) providing Behavior Therapy Services must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain a current Registered Behavior Technician (RBT) certification in good standing.
  - The RBT shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The RBT shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
- Supervision Requirements:
  - A Registered Behavior Technician (RBT) may provide Behavior Therapy Services only under the supervision of a Board-Certified Behavior Analyst (BCBA) and in accordance with the requirements established by the Behavior Analyst Certification Board (BACB) and applicable state and federal regulations.
  - The supervising BCBA is responsible for:
    - Oversight of service delivery;
    - Development and monitoring of behavioral interventions;
    - Review of participant progress and outcomes;
    - Clinical direction of behavior support activities; and
    - Ensuring services are delivered in accordance with the participant's PCSP and Behavior Intervention Plan (BIP), when applicable.
    - The RBT shall work within the scope of their certification and competency and may not independently perform functions that require a BCBA's clinical oversight or professional judgment.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **591** (BT-Registered Behavioral Technician using taxonomy 103TR0400X).
  - Required attachments are:
    - W9
    - Proof of CDDO Affiliation
    - Proof of RBT Certificate
    - Attestation: Staff Safety & Compliance Training
    - Attestation: RBT Supervision Requirement
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Behavior Therapy (BT) Provider

- Qualifications:
  - An Individual Behavior Therapy Provider must:
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
    - Maintain a current KDADS validation letter confirming that the provider has met the approved alternative qualification requirements for the delivery of Behavior Therapy Services.
  - To receive KDADS approval, the provider must meet one of the following qualification pathways:
    d. Qualification Option 1 – Master's Degree
    The provider must:
      - ❖ Hold a master's degree, preferably in Human Services, Education, or a related field.
      - ❖ Have documented experience working with individuals with intellectual or developmental disabilities.
      - ❖ Successfully complete a State-approved behavioral training curriculum, such as the Kansas Center for Autism Research and Training (KCART) program or another KDADS-approved curriculum.

    e. Qualification Option 2 – Alternative Behavioral Training Pathway
    The provider must:
      - ❖ Be at least 18 years of age.
      - ❖ Possess a high school diploma or equivalent.
      - ❖ Successfully complete 40 hours of Applied Behavior Analysis (ABA) training, including:
      - ❖ Eight hours of supervised intervention experience;
      - ❖ Three hours of ethics training;
      - ❖ One hour of criterion-referenced instruction;
      - ❖ One hour of social skills training;
      - ❖ One hour of parent training; and
      - ❖ One hour of program development training.
      - ❖ Demonstrate successful completion of an initial competency assessment administered or approved by KDADS.
  - The Individual Behavior Therapy Provider shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - ⌑ Abuse, neglect, and exploitation prevention;
      - ⌑ State law reporting requirements related to abuse, neglect, and exploitation;
      - ⌑ Cardiopulmonary Resuscitation (CPR); and
      - ⌑ Basic First Aid.
  - The provider shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention

Behavior Therapy (BT) Provider continued

- Supervision Requirements
  - Individual Behavior Therapy Providers may provide Behavior Therapy Services only under the supervision of a Board-Certified Behavior Analyst (BCBA).
  - The supervising BCBA is responsible for:
    - Clinical oversight of service delivery.
    - Development and monitoring of Behavior Intervention Plans (BIPs).
    - Review of participant progress and behavioral outcomes.
    - Guidance regarding intervention strategies and treatment implementation.
    - Ensuring services are delivered in accordance with professional standards and the participant's PCSP.
  - The Individual Behavior Therapy Provider shall practice within the scope of their approved qualifications and training and may not perform services requiring independent clinical authorization or BCBA-level decision making.

Licensed Psychologist (LP)

- Qualifications:
  - A Licensed Psychologist providing Behavior Therapy Services must:
    - Hold an active license issued by the Kansas Behavioral Sciences Regulatory Board (BSRB) in accordance with K.S.A. 74-5301 et seq.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Licensed Psychologist shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Licensed Psychologist shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
  - The Licensed Psychologist shall maintain the knowledge, skills, and competencies necessary to:
    - Conduct behavioral assessments and evaluations;
    - Perform Functional Behavior Assessments (FBAs) and other behavioral analyses;
    - Develop and oversee Behavior Intervention Plans (BIPs);
    - Implement evidence-based behavioral interventions;
    - Provide behavior consultation and clinical oversight; and
    - Support participants in achieving behavioral, emotional, social, and functional outcomes identified in the PCSP.

Supervision of Unlicensed Behavior Therapy Assistants

- In accordance with K.A.R. 102-8-6, K.A.R. 102-2-8, and K.A.R. 102-1-11, Behavior Therapy Services may be provided by an Unlicensed Behavior Therapy Assistant under the supervision of a Licensed Psychologist.
- The Licensed Psychologist shall comply with all applicable statutes, regulations, and professional standards established by the Kansas Behavioral Sciences Regulatory Board and is responsible for the supervision and oversight of assistant staff.
- Upon request by the State, the Licensed Psychologist shall provide:
  - Documentation of the assistant's qualifications, education, certifications, and training;
  - Documentation demonstrating the assistant's competency and performance level; and/or
  - A comprehensive list of duties and tasks performed by the assistant.
- Requirements for Unlicensed Behavior Therapy Assistants
  - Individuals functioning as Unlicensed Behavior Therapy Assistants must:
    - Meet the education, training, and certification requirements established in K.A.R. 102-1-11 and K.A.R. 102-2-8.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
      - A Medicaid-enrolled provider; or
      - An employee of a Medicaid-enrolled provider.

- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **593** (BT-Licensed Psychologist using taxonomy 103TR0400X).
  - Required attachments are:
    - W9
    - Proof of KSBSRB License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Licensed Social Worker (LSW)

- Qualifications:
  - A Licensed Social Worker providing Behavior Therapy Services must:
    - Hold an active license issued by the Kansas Behavioral Sciences Regulatory Board (BSRB) in accordance with K.S.A. 65-6301 et seq. as either:
      - A Licensed Master Social Worker (LMSW); or
      - A Licensed Specialist Clinical Social Worker (LSCSW),
      - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
      - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Licensed Social Worker shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Licensed Social Worker shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
  - The Licensed Social Worker shall maintain the knowledge, skills, and competencies necessary to:
    - Conduct behavioral assessments and observations.
    - Participate in the development and implementation of Behavior Intervention Plans (BIPs).
    - Provide behavior support services and skill-building interventions.
    - Support participants in developing adaptive, social, communication, coping, and self-regulation skills.
    - Coordinate with caregivers, service providers, employers, and other support team members to address behavioral needs.
    - Deliver services consistent with the participant’s PCSP.

Supervision of Unlicensed Behavior Therapy Assistants

- In accordance with K.A.R. 102-8-6, K.A.R. 102-2-8, and K.A.R. 102-1-11, Behavior Therapy Services may be provided by an Unlicensed Behavior Therapy Assistant under the supervision of an enrolled Licensed Social Worker.
- The Licensed Social Worker shall comply with all applicable statutes, regulations, professional standards, and licensing board requirements related to the supervision of assistant personnel.
- Upon request by the State, the Licensed Social Worker shall provide:
  - Documentation of the assistant’s qualifications, education, certifications, and training;
  - Documentation demonstrating the assistant’s competency and performance level; and/or
  - A comprehensive list of duties and tasks performed by the assistant.

Requirements for Unlicensed Behavior Therapy Assistants

- Individuals functioning as Unlicensed Behavior Therapy Assistants must:
  - Meet the education, training, and certification requirements established in K.A.R. 102-1-11 and K.A.R. 102-2-8.
  - Be at least 18 years of age.
  - Reside outside of the participant's residence.
  - Be either:
    - A Medicaid-enrolled provider; or
    - An employee of a Medicaid-enrolled provider.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty 594 (BT-Licensed Social Worker using taxonomy 103TR0400X).
  - Required attachments are:
    - W9
    - Proof of LMSW/LSCSW License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Certified Behavior Analyst (CBA)

- Qualifications:
  - A Certified Behavior Analyst providing Behavior Therapy Services must:
    - Maintain a current certification as one of the following:
      - Board-Certified Behavior Analyst (BCBA);
      - Board-Certified Behavior Analyst – Doctoral (BCBA-D); or
      - Board-Certified Assistant Behavior Analyst (BCaBA).
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Certified Behavior Analyst shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The CBA shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention

Certified Behavior Analyst (CBA)

- The Certified Behavior Analyst shall maintain the knowledge, skills, and competencies necessary to:
  - Conduct behavioral assessments and evaluations.
  - Perform Functional Behavior Assessments (FBAs) and behavioral analyses.
  - Develop, implement, and monitor Behavior Intervention Plans (BIPs).
  - Provide skill acquisition and behavior reduction interventions.
  - Deliver crisis prevention and behavior support strategies.
  - Supervise behavior therapy staff and assistants, as applicable.
  - Support participants in achieving behavioral, social, emotional, adaptive, and community integration goals identified in the PCSP.

Supervision of Unlicensed Behavior Therapy Assistants

- In accordance with K.A.R. 102-8-6, Behavior Therapy Services may be provided by an Unlicensed Behavior Therapy Assistant under the supervision of an enrolled Certified Behavior Analyst or other qualified enrolled provider, as permitted by applicable statutes, regulations, and certification requirements.
- The Certified Behavior Analyst shall comply with all applicable certification standards, professional practice requirements, and regulatory requirements governing supervision.
- Upon request by the State, the Certified Behavior Analyst shall provide:
  - Documentation of the assistant's qualifications, education, certifications, and training;
  - Documentation demonstrating the assistant's competency and performance level; and/or
  - A comprehensive list of duties and tasks performed by the assistant.

Requirements for Unlicensed Behavior Therapy Assistants

- Individuals functioning as Unlicensed Behavior Therapy Assistants must:
  - Meet the education, training, and certification requirements established in K.A.R. 102-1-11 and K.A.R. 102-2-8.
  - Be at least 18 years of age.
  - Reside outside of the participant’s residence.
  - Be either:
    - A Medicaid-enrolled provider; or
    - An employee of a Medicaid-enrolled provider.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **595** (BT-Certified Behavior Analyst using taxonomy 103TR0400X).
  - Required attachments are:
    - W9
    - Proof of BCBA/BCBA-D/BCaBA Certificate
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

OCCUPATIONAL THERAPY (OT)

Service Definition

Occupational Therapy is a therapeutic service designed to help participants develop, improve, restore, or maintain the physical, cognitive, perceptual, and adaptive skills necessary to perform everyday activities and participate as independently as possible in home, work, and community environments. Occupational Therapy focuses on the impact of an individual's intellectual or developmental disability on daily functioning and overall quality of life.

Occupational Therapy evaluates and addresses a participant's:

- Motor skills and physical functioning;
- Postural control and movement patterns;
- Cognitive and perceptual abilities;
- Sensory processing needs; and
- Ability to safely perform meaningful daily activities.

The service is individualized and designed to increase functional independence, maximize participation in daily life, and support successful community living.

Covered Services

Occupational Therapy may include the following activities:

- **Evaluation and Assessment:** Occupational Therapy evaluations may include assessment of:
  - Activities of Daily Living (ADLs);
  - Fine motor and gross motor skills;
  - Sensory processing and integration needs;
  - Cognitive and perceptual functioning;
  - Functional mobility and positioning;
  - Environmental accessibility needs; and
  - Adaptive equipment requirements.
- **Activities of Daily Living (ADL) Training:** Therapeutic interventions designed to improve the participant's ability to perform everyday activities independently, including:
  - Dressing;
  - Bathing and personal hygiene;
  - Feeding and eating;
  - Grooming;
  - Toileting; and
  - Other self-care activities.
- Skill Development and Therapeutic Intervention: Occupational Therapy may include:
  - Strengthening and coordination activities;
  - Motor skill development;
  - Sensory integration strategies;
  - Cognitive skill development;
  - Functional task training; and
  - Therapeutic exercises that improve independence and daily functioning.
- **Adaptive Equipment and Environmental Modification:** When participants are unable to perform activities independently through skill development alone, Occupational Therapy may include:
  - Assessment for adaptive equipment;
  - Recommendations for assistive technology;
  - Environmental modification recommendations;
  - Training on the use of adaptive equipment; and
  - Instruction on alternative techniques for completing daily activities.

Covered Services continued

- **Independence and Community Living Supports:** Therapeutic interventions may focus on increasing the participant's ability to:
  - Function safely within the home;
  - Participate in community activities;
  - Access employment or educational opportunities;
  - Increase self-sufficiency; and
  - Maintain the highest possible level of independence.

Occupational Therapy Services may be provided:

- In the participant's home; or
- At the provider's place of business.

Services shall be delivered in accordance with professional standards of practice and based on the participant's assessed needs and treatment goals.

Physician Authorization Requirement

Occupational Therapy Services require a valid prescription or referral from one of the following licensed healthcare professionals:

- Physician;
- Physician Assistant (PA); or
- Advanced Practice Registered Nurse (APRN).

Documentation of the prescription or referral must be maintained in the participant's record and made available upon request.

Service Limitations

Occupational Therapy Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Be medically or functionally necessary to improve, restore, maintain, or prevent deterioration of functional abilities.
- Support participant independence and community integration.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - Educational services;
  - Other waiver services; or
  - Any other formal or informal supports available to the participant.

Non-Covered Services

Occupational Therapy Services:

- May not duplicate therapy services available through another funding source.
- May not be provided solely for recreational purposes.
- May not include services that are primarily educational in nature.
- May not be provided without the required physician, PA, or APRN prescription.

Billing or Service Code(s)

- The Occupational Therapy services are covered when rendered by the provider type and specialties, **55/596** (Occupational Therapy), or **55/599** (Therapy Services- Home Health Agency). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
G0152-U8	Each 15-minute	55/596, 55/599

Occupational Therapy services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – OT

Occupational therapy services may be provided by:

- Occupational Therapist – **55/596**
- Home Health Agency (HHA) – **55/599**

Occupational Therapist

- Qualifications:
  - An Occupational Therapist providing Occupational Therapy Services must:
    - Hold an active license issued by the Kansas State Board of Healing Arts in accordance with K.S.A. 65-5401 et seq.
    - Provide services in accordance with all applicable state licensing statutes, regulations, and professional practice standards governing occupational therapy services.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Occupational Therapist shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Occupational Therapist shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
  - The Occupational Therapist shall maintain the knowledge, skills, and competencies necessary to:
    - Conduct occupational therapy evaluations and assessments.
    - Evaluate motor skills, posture, perceptual abilities, cognitive functioning, and activities of daily living.
    - Develop and implement individualized treatment plans.
    - Provide therapeutic interventions designed to improve functional independence.
    - Assess and recommend adaptive equipment, assistive technology, and environmental modifications.
    - Train participants, caregivers, and support staff in the use of adaptive strategies and equipment.

Occupational Therapist

- Support participants in achieving goals identified in the PCSP.
  - Supervision of Occupational Aides, Technicians, and Paraprofessionals
  - In accordance with K.S.A. 65-5419, K.A.R. 100-54-10, and other applicable statutes and regulations, Occupational Therapy Services may be provided by an Occupational Aide, Occupational Therapy Technician, or Occupational Therapy Paraprofessional under the supervision of an enrolled licensed Occupational Therapist.
  - The Occupational Therapist shall comply with all requirements established by the Kansas State Board of Healing Arts and any other applicable licensing authority regarding supervision, delegation, and service delivery.
- Upon request by the State, the Occupational Therapist shall provide:
  - A comprehensive list of tasks delegated to and performed by the aide, technician, or paraprofessional.
  - Documentation of training completed by the aide, technician, or paraprofessional.
  - Documentation demonstrating the aide, technician, or paraprofessional's competency to perform delegated tasks.

- Requirements for Occupational Aides, Technicians, and Paraprofessionals
  - Individuals serving as an Occupational Aide, Occupational Therapy Technician, or Occupational Therapy Paraprofessional must:
    - Meet the education, training, and certification requirements established in K.A.R. 100-54-2 and K.A.R. 100-54-3.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
    - A Medicaid-enrolled provider; or
    - An employee of a Medicaid-enrolled provider.
  - Occupational Aides, Technicians, and Paraprofessionals may perform only those tasks permitted under applicable regulations and delegated by the supervising Occupational Therapist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **596** (Occupational Therapist using taxonomy 225XP0019X).
  - Required attachments are:
    - W9
    - Proof of KBHA License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Home Health Agency (HHA)

- Qualifications:
  - A Home Health Agency (HHA) providing Occupational Therapy services must:
    - Be licensed and operated in accordance with K.S.A. 65-5101 et seq. and K.A.R. 28-51-100 et seq.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Home Health Agency shall ensure that Occupational Therapy Services are provided only by qualified professionals who:
    - Hold an active Occupational Therapist license issued by the Kansas State Board of Healing Arts in accordance with K.S.A. 65-5401 et seq.
    - Practice in accordance with all applicable state licensing statutes, regulations, and professional standards.
  - The Home Health Agency shall ensure that all staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Home Health Agency shall ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention,
  - The Home Health Agency shall ensure staff possess the knowledge, skills, and competencies necessary to:
    - Conduct occupational therapy evaluations and assessments.
    - Evaluate physical, motor, cognitive, perceptual, and functional abilities.
    - Develop and implement individualized treatment plans.
    - Provide therapeutic interventions that improve functional independence and activities of daily living.
    - Assess the need for adaptive equipment, assistive technology, and environmental modifications.
    - Train participants, caregivers, and support staff in therapeutic techniques and adaptive strategies.
    - Support participants in achieving goals identified in the PCSP.
      - Supervision of Occupational Aides, Technicians, and Paraprofessionals
      - In accordance with K.S.A. 65-5419 and K.A.R. 100-54-10, Occupational Therapy Services may be provided by an Occupational Aide, Occupational Therapy Technician, or Occupational Therapy Paraprofessional under the supervision of an enrolled licensed Occupational Therapist employed by the Home Health Agency.
      - The Home Health Agency and supervising Occupational Therapist shall comply with all applicable statutes, regulations, licensing requirements, and professional standards governing delegation and supervision.

Home Health Agency (HHA)

- Upon request by the State, the supervising Occupational Therapist shall provide:
  - A comprehensive list of delegated tasks performed by the aide, technician, or paraprofessional.
  - Documentation of training completed by the aide, technician, or paraprofessional.
  - Documentation demonstrating competency to perform assigned tasks.

- Requirements for Occupational Aides, Technicians, and Paraprofessionals
  - Individuals serving in these roles must:
    - Meet the education, training, and certification requirements established in K.A.R. 100-54-2 and K.A.R. 100-54-3.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
      - A Medicaid-enrolled provider; or
      - An employee of a Medicaid-enrolled provider.
  - Occupational Aides, Technicians, and Paraprofessionals may perform only those duties permitted under applicable regulations and delegated by the supervising Occupational Therapist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **599** (Therapy Services-Home Health Agency using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Proof that all professions (OT or PT or SLT) cited in waiver has requisite licensure or certifications
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

PHYSICAL THERAPY (PT)

Service Definition

Physical Therapy is a therapeutic service designed to improve, restore, maintain, or prevent the loss of physical functioning, mobility, strength, and endurance. Physical Therapy helps participants achieve the highest possible level of independence by addressing movement limitations and improving the ability to perform functional activities necessary for daily living and community participation.

Physical Therapy focuses on evaluating and treating physical impairments, functional limitations, and mobility challenges associated with a participant's intellectual or developmental disability, medical condition, or physical impairment.

Covered Services

Physical Therapy may include the following activities:

- **Evaluation and Assessment:** Physical Therapy evaluations may include assessment of:
  - Functional mobility;
  - Strength and endurance;
  - Balance and coordination;
  - Posture and positioning;
  - Range of motion;
  - Muscle tone and motor function;
  - Gait and walking abilities; and
  - Functional limitations affecting daily activities.
- **Therapeutic Intervention:** Physical Therapy services may include interventions designed to:
  - Improve mobility and movement patterns;
  - Increase strength and endurance;
  - Enhance balance and coordination;
  - Improve postural control;
  - Maintain or increase range of motion;
  - Prevent loss of physical function; and
  - Support participation in daily activities and community environments.
- **Functional Mobility Training:** Physical Therapy may include training and interventions that support:
  - Standing and transfers;
  - Sitting and positioning;
  - Walking and gait training;
  - Mobility within the home and community;
  - Safe movement techniques; and
  - Functional independence.
- **Adaptive Equipment Assessment and Training:** When necessary, Physical Therapy may include:
  - Assessment for adaptive equipment and mobility devices;
  - Recommendations for assistive technology and therapeutic equipment;
  - Training on proper use of equipment;
  - Positioning recommendations; and
  - Strategies to compensate for physical limitations.
- **Health, Wellness, and Prevention:** Physical Therapy may support participants in:
  - Maintaining an active lifestyle;
  - Preventing functional decline;
  - Improving physical health and well-being;
  - Reducing risk of injury; and
  - Maximizing long-term physical independence.

Covered Services continued

Physical Therapy Services may be provided:

- In the participant's home; or
- At the provider's place of business.

Services shall be delivered in accordance with professional standards of practice and individualized to meet the participant's assessed needs and treatment goals.

Physician Authorization Requirement

Physical Therapy Services require a valid prescription or referral from one of the following licensed healthcare professionals:

- Physician;
- Physician Assistant (PA); or
- Advanced Practice Registered Nurse (APRN).

Documentation of the prescription or referral must be maintained in the participant's record and made available upon request.

Service Limitations

Physical Therapy Services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Be medically or functionally necessary to improve, restore, maintain, or prevent the loss of physical functioning.
- Support participant independence and community integration.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
  - Vocational Rehabilitation;
  - Educational services;
  - Other waiver services; or
  - Any other formal or informal supports available to the participant.

Non-Covered Services

Physical Therapy Services:

- May not duplicate therapy services available through another funding source.
- May not be provided solely for recreational or fitness purposes.
- May not include services that are primarily educational in nature.
- May not be provided without the required physician, PA, or APRN prescription.

Billing or Service Code(s)

- The Physical Therapy services are covered when rendered by the provider type and specialties, **55/597** (Physical Therapy), or **55/599** (Therapy Services- Home Health Agency). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
G0151-U8	Each 15-minute	55/597, 55/599

Physical Therapy services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – PT

Physical therapy services may be provided by:

- Physical Therapist – **55/597**
- Home Health Agency (HHA) – **55/599**

Physical Therapist

- Qualifications:
  - A Physical Therapist providing Physical Therapy Services must:
    - Hold an active license issued by the Kansas State Board of Healing Arts in accordance with K.S.A. 65-5401 et seq.
    - Provide services in accordance with all applicable state licensing statutes, regulations, and professional practice standards governing physical therapy services.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Physical Therapist shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Occupational Therapist shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention
  - The Physical Therapist shall maintain the knowledge, skills, and competencies necessary to:
    - Conduct physical therapy evaluations and assessments.
    - Evaluate mobility, strength, balance, coordination, endurance, posture, muscle tone, and functional movement.
    - Develop and implement individualized treatment plans.
    - Provide therapeutic interventions that improve mobility, physical functioning, and independence.
    - Assess the need for adaptive equipment, mobility devices, and therapeutic supports.
    - Train participants, caregivers, and support staff in therapeutic exercises, mobility techniques, and use of adaptive equipment.
    - Support participants in achieving goals identified in the PCSP.

Physical Therapist continued

- Supervision of Physical Therapist Assistants
  - In accordance with K.A.R. 100-29-16, K.S.A. 65-2909, K.S.A. 65-2910, and K.S.A. 65-2918, Physical Therapy Services may be provided by a Physical Therapist Assistant (PTA) under the supervision of an enrolled licensed Physical Therapist.
  - The Physical Therapist shall comply with all applicable statutes, regulations, licensing requirements, and professional standards governing supervision and delegation of services.
- Upon request by the State, the Physical Therapist shall provide:
  - A comprehensive list of delegated tasks performed by the Physical Therapist Assistant.
  - Documentation of the Physical Therapist Assistant's education, training, experience, and skill level.
  - Documentation identifying the setting in which services are delivered.
  - Documentation regarding the complexity and acuity of the participant's condition or health status.

- Requirements for Physical Therapist Assistants (PTAs)
  - A Physical Therapist Assistant must:
    - Meet the education, training, licensure, and certification requirements established in K.A.R. 100-29-2, K.A.R. 100-29-3, K.S.A. 65-2909, and K.S.A. 65-2910.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
      - A Medicaid-enrolled provider; or
      - An employee of a Medicaid-enrolled provider.
  - Physical Therapist Assistants may perform only those duties permitted under applicable statutes and regulations and delegated by the supervising Physical Therapist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **597** (Physical Therapist using taxonomy 2251H1300X).
  - Required attachments are:
    - W9
    - Proof of KBHA License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Home Health Agency (HHA)

- Qualifications:
  - A Home Health Agency (HHA) providing Physical Therapy services must:
    - Be licensed and operated in accordance with K.S.A. 65-5101 et seq. and K.A.R. 28-51-100 et seq.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Home Health Agency shall ensure that Physical Therapy Services are provided only by qualified professionals who:
    - Hold an active license issued by the Kansas State Board of Healing Arts in accordance with K.S.A. 65-5401 et seq.
    - Practice in accordance with all applicable state licensing statutes, regulations, and professional standards.
  - The Home Health Agency shall ensure that all staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Home Health Agency shall ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention,
  - The Home Health Agency shall ensure staff possess the knowledge, skills, and competencies necessary to:
    - Conduct physical therapy evaluations and assessments.
    - Evaluate mobility, strength, balance, coordination, endurance, posture, muscle tone, and functional movement.
    - Develop and implement individualized treatment plans.
    - Provide therapeutic interventions designed to improve mobility, physical functioning, and independence.
    - Assess and recommend adaptive equipment, mobility devices, and therapeutic supports.
    - Train participants, caregivers, and support staff in therapeutic exercises, mobility techniques, and the use of adaptive equipment.
    - Support participants in achieving goals identified in the PCSP.
      - Supervision of Physical Therapy Assistants
      - In accordance with K.A.R. 100-29-16, K.S.A. 65-2909, K.S.A. 65-2910, and K.S.A. 65-2918, Physical Therapy Services may be provided by a Physical Therapist Assistant (PTA) under the supervision of an enrolled licensed Physical Therapist employed by the Home Health Agency.

Home Health Agency (HHA)

- The Home Health Agency and supervising Physical Therapist shall comply with all applicable statutes, regulations, licensing requirements, and professional standards governing supervision and delegation of services.
- Upon request by the State, the supervising Physical Therapist shall provide:
  - A comprehensive list of delegated tasks performed by the Physical Therapist Assistant.
  - Documentation of the Physical Therapist Assistant's education, training, experience, and skill level.
  - Documentation identifying the setting in which services are delivered.
  - Documentation regarding the complexity and acuity of the participant's condition or health status.

- Requirements for Physical Therapy Assistants
  - A Physical Therapist Assistant must:
    - Meet the education, training, licensure, and certification requirements established in K.A.R. 100-29-2, K.A.R. 100-29-3, K.S.A. 65-2909, and K.S.A. 65-2910.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
      - A Medicaid-enrolled provider; or
      - An employee of a Medicaid-enrolled provider.
  - Physical Therapist Assistants may perform only those duties permitted under applicable statutes and regulations and delegated by the supervising Physical Therapist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **599** (Therapy Services-Home Health Agency using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Proof that all professions (OT or PT or SLT) cited in waiver has requisite licensure or certifications
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

SPEECH AND LANGUAGE THERAPY (SLT)

Service Definition

Speech and Language Therapy is a therapeutic service designed to assess, treat, and improve communication, language, speech, cognitive-communication, and swallowing disorders that may affect a participant's ability to function independently and participate in daily life. The service helps participants develop, maintain, or restore the skills necessary for effective communication, social interaction, learning, and overall quality of life.

SLT addresses challenges related to understanding, expressing, and processing information, as well as conditions that impact speech production, cognition, swallowing, and respiratory support for communication.

Covered Services

Speech-Language Therapy may include the following activities:

- **Evaluation and Assessment:** SLT evaluations may include assessment of:
  - Receptive language skills (understanding spoken or written language);
  - Expressive language skills (communicating thoughts, ideas, and needs);
  - Speech production and articulation;
  - Motor speech functioning;
  - Cognitive-communication abilities;
  - Social and conversational communication skills;
  - Swallowing and feeding abilities; and
  - Respiratory support for communication and swallowing functions.
- **Communication and Language Intervention:** SLT may provide interventions designed to improve:
  - Listening and comprehension skills;
  - Verbal and non-verbal communication;
  - Speech clarity and intelligibility;
  - Reading and writing skills;
  - Vocabulary development;
  - Functional communication;
  - Social communication and conversational skills; and
  - Communication independence across settings.
- **Cognitive-Communication Training:** Therapeutic interventions may address:
  - Attention and concentration;
  - Memory skills;
  - Sequencing and organization;
  - Planning and time management;
  - Problem-solving and reasoning abilities; and
  - Executive functioning skills necessary for daily living.
- **Speech and Motor Speech Therapy:** Services may include treatment of:
  - Articulation disorders;
  - Motor speech disorders;
  - Voice disorders;
  - Fluency disorders; and
  - Other speech production challenges affecting communication effectiveness.

Covered Services continued

- **Swallowing and Feeding Therapy:** SLT may include assessment and treatment related to:
  - Swallowing disorders (dysphagia);
  - Feeding difficulties;
  - Safe eating and drinking practices;
  - Oral motor functioning; and
  - Respiratory factors that affect swallowing safety.
- **Adaptive Communication Supports:** When appropriate, SLT may include:
  - Assessment for augmentative and alternative communication (AAC) systems;
  - Recommendations for adaptive communication equipment;
  - Training on communication devices and assistive technology; and
  - Education for caregivers and support team members regarding communication supports.

SLT services may be provided:

- In the participant's home; or
- At the provider's place of business.

Services shall be individualized to meet the participant's assessed needs and delivered in accordance with professional standards of practice.

Physician Authorization Requirement

SLT services require a valid prescription or referral from one of the following licensed healthcare professionals:

- Physician;
- Physician Assistant (PA); or
- Advanced Practice Registered Nurse (APRN).

Documentation of the prescription or referral must be maintained in the participant's record and made available upon request.

Service Limitations

SLT services must:

- Be based on the participant's assessed needs.
- Be authorized through the participant's PCSP.
- Be medically or functionally necessary to improve, restore, maintain, or prevent the loss of communication, cognitive-communication, or swallowing abilities.
- Support participant independence, communication, and community integration.
- Not duplicate services available through:
  - The Medicaid State Plan;
  - EPSDT;
  - Vocational Rehabilitation;
  - Educational services;
  - Other waiver services; or
  - Any other formal or informal supports available to the participant.

Non-Covered Services

SLT services:

- May not duplicate therapy services available through another funding source.
- May not be provided solely for educational instruction.
- May not include services that are primarily recreational in nature.
- May not be provided without the required physician, PA, or APRN prescription.

Billing or Service Code(s)

- The Speech and Language Therapy services are covered when rendered by the provider type and specialties, **55/598** (Speech and Language Therapy), or **55/599** (Therapy Services- Home Health Agency). The providers must enroll under the listed specialties to be eligible for the reimbursement.

Code-Modifier	Unit Definition	Covered Provider Specialty
G0153-U8	Each 15-minute	55/598, 55/599

Speech and Language Therapy services are subject to the EVV requirements.

Provider Qualifications and Enrollment Requirements – SLT

SLT services may be provided by:

- Speech Language Pathologist (SLP) – 55/598
- Home Health Agency (HHA) – 55/599

Requirements for Speech Language Pathologist (SLP)

- Qualifications:
  - An SLP providing Speech and Language Therapy services must:
    - Hold an active license issued by the Kansas Department for Aging and Disability Services (KDADS) in accordance with K.S.A. 65-6501 et seq. and K.A.R. 28-61.
    - Provide services in accordance with all applicable state licensing statutes, regulations, and professional practice standards governing speech-language pathology services.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Speech-Language Pathologist shall:
    - Be authorized to work in the United States.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Speech-Language Pathologist shall complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention

Requirements for Speech Language Pathologist (SLP) continued

- The Speech-Language Pathologist shall maintain the knowledge, skills, and competencies necessary to:
  - Conduct speech, language, communication, cognitive-communication, and swallowing assessments.
  - Develop and implement individualized treatment plans.
  - Provide speech-language, communication, cognitive, and dysphagia interventions.
  - Assess the need for augmentative and alternative communication (AAC) devices and other communication supports.
  - Train participants, caregivers, and support staff in communication strategies and adaptive techniques.
  - Support participants in achieving goals identified in the PCSP.

- Supervision of Speech-Language Pathology Assistants
  - In accordance with K.S.A. 65-6501 et seq. and K.A.R. 28-61, Speech-Language Therapy Services may be provided by a Speech-Language Pathology Assistant (SLPA) under the supervision of an enrolled licensed Speech-Language Pathologist.
  - The Speech-Language Pathologist shall comply with all applicable statutes, regulations, licensing requirements, and professional standards governing supervision and delegation of services.
  - Upon request by the State, the Speech-Language Pathologist shall provide:
    - Documentation of the assistant's qualifications, education, certifications, and training.
    - Documentation demonstrating the assistant's competency and performance level.
    - A comprehensive list of duties and tasks performed by the assistant.

Requirements for Speech-Language Pathology Assistants (SLPAs)

- A Speech-Language Pathology Assistant must:
  - Meet the education, training, and certification requirements established in K.A.R. 28-61-8.
  - Be at least 18 years of age.
  - Reside outside of the participant's residence.
  - Be either:
    - A Medicaid-enrolled provider; or
    - An employee of a Medicaid-enrolled provider.
- Speech-Language Pathology Assistants may perform only those duties permitted under applicable statutes and regulations and delegated by the supervising Speech-Language Pathologist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Individual provider under provider specialty **598** (Speech Language Pathologist using taxonomy 2355S0801X).
  - Required attachments are:
    - W9
    - Proof of KDADS License
    - Proof of CDDO Affiliation
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

Provider Qualifications and Enrollment Requirements – SLT continued

Home Health Agency (HHA)

- Qualifications:
  - A Home Health Agency (HHA) providing Speech and Language Therapy services must:
    - Be licensed and operated in accordance with K.S.A. 65-5101 et seq. and K.A.R. 28-51-100 et seq.
    - Be contracted with a KanCare MCO or hold the status of an approved out-of-network provider.
    - Maintain affiliation with the CDDO serving the participant's catchment area in accordance with K.A.R. 30-63-31.
  - The Home Health Agency shall ensure that SLT services are provided only by qualified professionals who:
    - Hold an active Speech-Language Pathologist license issued by the KDADS.
    - Practice in accordance with all applicable state licensing statutes, regulations, and professional standards.
  - The Home Health Agency shall ensure that all staff delivering direct services and supports:
    - Are authorized to work in the United States.
    - Meet all applicable employment standards established by the employing agency.
    - Maintain training in the following areas and provide evidence of current certificate completion from an accredited source when applicable or upon request:
      - Abuse, neglect, and exploitation prevention;
      - State law reporting requirements related to abuse, neglect, and exploitation;
      - Cardiopulmonary Resuscitation (CPR); and
      - Basic First Aid.
  - The Home Health Agency shall ensure staff complete annual KDADS-approved training as specified in the CSW, Appendix G-2, covering:
    - Restraint;
    - Restrictive interventions;
    - Crisis prevention, including positive behavioral supports; and
    - Crisis intervention,
  - The Home Health Agency shall ensure staff possess the knowledge, skills, and competencies necessary to:
    - Conduct speech, language, cognitive-communication, and swallowing assessments.
    - Develop and implement individualized treatment plans.
    - Provide speech, language, communication, cognitive, and dysphagia interventions.
    - Assess the need for augmentative and alternative communication (AAC) devices and communication supports.
    - Train participants, caregivers, and support staff in communication strategies, adaptive techniques, and use of communication equipment.
    - Support participants in achieving goals identified in the PCSP.
      - Supervision of Speech-Language Pathology Assistants
      - In accordance with K.S.A. 65-6501 et seq. and K.A.R. 28-61, Speech-Language Therapy Services may be provided by a Speech-Language Pathology Assistant (SLPA) under the supervision of an enrolled licensed Speech-Language Pathologist employed by the Home Health Agency.
      - The Home Health Agency and supervising Speech-Language Pathologist shall comply with all applicable statutes, regulations, licensing requirements, and professional standards governing supervision and delegation of services.

Provider Qualifications and Enrollment Requirements – SLT continued

Home Health Agency (HHA)

- Upon request by the State, the supervising SLP shall provide:
  - Documentation of the assistant's qualifications, education, certifications, and training.
  - Documentation demonstrating the assistant's competency and performance level.
  - A comprehensive list of duties and tasks performed by the assistant.

- Requirements for Speech-Language Pathology Assistants (SLPAs)
  - An SLPA must:
    - Meet the education, training, licensure, and certification requirements established in K.A.R. 28-61-8.
    - Be at least 18 years of age.
    - Reside outside of the participant's residence.
    - Be either:
      - A Medicaid-enrolled provider; or
      - An employee of a Medicaid-enrolled provider.
  - SLPAs may perform only those duties permitted under applicable statutes and regulations and delegated by the supervising Physical Therapist.
- KMMS Enrollment:
  - Must enroll in KMMS as an Agency provider under provider specialty **599** (Therapy Services-Home Health Agency using taxonomy 251E00000X).
  - Required attachments are:
    - W9
    - Proof of HHA License
    - Proof of CDDO Affiliation
    - Proof that all professions (OT or PT or SLT) cited in waiver has requisite licensure or certifications
    - Attestation: Staff Safety & Compliance Training
    - Attestation: Licensing Board Compliance
    - Attestation: Assistant Qualifications & Documentation
    - Attestation: Proof of Work Authorization
    - Declaration Sheet and/or Certificate of Insurance
    - HCBS Credential Supplemental Form
  - Must maintain an active provider enrollment record.

APPENDIX

DEFINITIONS

Affiliate – a local agency or individual which provides at least one service to members who are intellectually or developmentally disabled and has entered into an affiliation agreement with the recognized CDDO.

Behavior Assessment – a component of the functional eligibility assessment measuring the frequency in exhibiting certain behaviors (e.g. damages own or others property, is self-injurious, resists supervision) to determine the level and type of supervision needed to meet the individual's needs.

Behavior Support Plan – a plan that assists a member in building positive behaviors to replace or reduce a challenging/dangerous behavior. This plan may include teaching, improving communication, increasing relationships, and using clinical interventions.

Community Developmental Disability Organization (CDDO) – a local agency, specified by county government, which directly receives county mill funds and state aid and either directly and/or through a network of affiliates provides community-based services to members who are intellectually or developmentally disabled, and is formally recognized by KDADS.

Dependent/Immediate Family Members – As defined by the IRS, a spouse, child, parent, brother, sister, grandparent, grandchild, step-parent, step-child, step-brother, or step-sister of the individual in the military (IRM 1.25.1.2.2) who is claimed on the military personnel's federal income tax return as a dependent qualifying widower and dependent child, qualifying child or qualifying relative as established in the IRS Publication 501.

Functional Assessment – The current KDADS approved tool used by a state-contracted assessor to assess a person's functional eligibility.

Financial Eligibility – The process whereby a member is determined to be eligible for health care coverage for reimbursement through Medicaid as determined by an authorized agent or personnel designated by the State. In this case, the Single State Medicaid Agency is the KDHE.

Functional Eligibility Assessment – evaluation of the medical, adaptive, and behavioral needs and functional capacities of an individual to determine the level of care required to meet his or her needs in the least restrictive setting.

DEFINITIONS continued

I/DD Eligibility Requirement – the individual must either have substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is characterized by significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, or has a severe, chronic disability, with all of the following:

- Is attributable to a mental or physical impairment, or multiple sensory impairments, a combination of mental and physical impairments, physical and sensory impairments, mental and sensory impairments or a condition that has received a dual diagnosis of intellectual or developmental disability
- Is manifest before 22 years of age
- Is likely to continue indefinitely
- Results, in the case of a person five years of age or older, in a substantial limitation in three or more of the following areas of major life functioning: self-care; receptive and expressive language development and use; learning and adapting; mobility; self-direction; capacity for independent living; and economic self-sufficiency
- Reflects a need for a combination and sequence of special interdisciplinary or generic care, treatment, specialized communications techniques, or other services which are lifelong, or extended in duration, and are individually planned and coordinated.
- Does not include individuals who are solely and severely emotionally disturbed or seriously or persistently mentally ill or have disabilities solely as a result of the infirmities of aging.

I/DD Screening – an assessment of the adaptive needs, maladaptive behaviors, and health needs of the members who are intellectually or developmentally disabled to determine their eligibility for ICF-IID level of care.

Military Personnel – Active or reserve duty members of the armed forces including the United States Army, Navy, Marines, Air Force and Coast Guard, as well as, the activated Kansas National Guard.

Person-Centered Service Plan – process required by federal regulation led by the individual requiring waiver services or their representative that documenting the services, supports, and settings that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

Plan of Care (POC) – a document completed following the determination of ICF-IID eligibility, after the member elects HCBS I/DD instead of ICF-IID services. This document, subject to the approval of the HCBS I/DD program manager, must include:

- The services to be provided
- The frequency of each service
- The provider of each service
- The cost of each service

Program Eligibility – The process whereby a member is determined to be eligible for a Medicaid-funded KDADS HCBS waiver program as determined by KDADS or its designated State agency.

DEFINITIONS continued

Resident – A citizen of the United States who has a fixed home in Kansas, does not intend to leave Kansas and whenever absent, if for temporary purposes, intends to return to Kansas as evidenced by several factors found in K.A.R. 92-12-4a, including, but not limited to, spending more than six months of the taxable year in Kansas, voting or being registered to vote in Kansas, obtaining or maintaining a current valid driver's license or non-driver identification card, and paying Kansas income and property taxes and that person's domicile is within Kansas.

State-Contracted Assessor – Authorized agent or personnel, approved by the State, responsible for completing the functional eligibility assessments for individuals applying for KDADS HCBS waiver programs.