Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS
Technology Assisted

Updated 02.2026

PART II

HCBS TECHNOLOGY ASSISTED FEE-FOR-SERVICE PROVIDER MANUAL

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

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

INTRODUCTION TO THE HCBS TA PROGRAM

Updated 05/19

The purpose for the Home and Community Based Services (HCBS) Technology Assisted (TA) waiver program is to provide eligible Kansans who are 0 through 21 years of age and would otherwise require institutionalization in a hospital setting a choice to receive needed services in their home and community. The goals and objectives of this waiver are to provide individuals who are medically fragile and require life-sustaining medical technology the opportunity to access long-term care services intended to assist individuals in managing their healthcare limitations in order to progress towards independence, productivity, and community integration and inclusion. The waiver is intended to provide supports and services to meet the medical needs of the individuals and will be provided in a manner that affords the same dignity and respect provided to any person who does not have a disability.

TA waiver members will receive an initial assessment and reassessment for continued level of care eligibility determination utilizing a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. The initial level of care eligibility and reassessment after six months will be completed by a contracted MATLOC Eligibility Specialist (MES).

The plan of care will be developed and provided as a part of a comprehensive package of services offered by the KanCare MCOs and will be paid as part of a capitated rate. The health plans are responsible for assigning a nurse case manager/care coordinator who will conduct a comprehensive needs assessment and develop a person-centric plan of care that includes both state plan services and, as appropriate, TA waiver services.

The HCBS TA waiver program provides opportunities for the following:

- Health Maintenance Monitoring
- Home Modification
- Financial Management Services (FMS)
  Note: Refer to the *HCBS Financial Management Services Fee-for-Service Provider Manual* for criteria and information.
- Intermittent Intensive Medical Care
- Personal Care Services
- Medical Respite
- Specialized Medical Care
  - Licensed practical nurse (LPN)
  - Registered nurse (RN)

INTRODUCTION TO THE HCBS TA PROGRAM

Updated 05/19

Prior authorizations are required for all HCBS services and must be submitted by the assigned care coordinator. A utilization management team separate from the care coordination team completes the final reviews of the authorization to ensure that the member is eligible for the requested waiver service and the documentation supports the proposed service plan. Inter-rater reliability activities are also conducted regularly with the utilization management team.

This provider specific section of the manual (Part II) is designed to provide information and instructions specific to providers of HCBS TA waiver program services. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection provides instructions on claim submission.

The **Benefits and Limitations** subsection outlines services included for HCBS TA members and limitations on these services. It also includes qualifications for HCBS TA providers, documentation requirements for reimbursement, and expected service outcomes.

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

In addition to the information in these provider manuals, service providers must comply with specific TA waiver program operational protocols.

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

INTRODUCTION TO THE HCBS TA PROGRAM

Updated 11/17

HCBS TA enrollment

Potential providers must complete a Kansas Medical Assistance Program (KMAP) provider enrollment application and submit their credentials and qualifications with the application. The fiscal agent reviews the information and forwards it to the HCBS TA program manager. Once the program manager determines the provider meets the qualifications, the fiscal agent notifies the applicant of the enrollment determination. Once enrolled, the provider receives a provider number. Provider enrollment information is available on the KMAP website.

Miscellaneous documentation requirement

With the transition to an Electronic Verification and Monitoring (EV&M) system through KS AuthentiCare, recoupments are no longer identified solely based on the lack of meeting documentation requirements for dates of service from January 1 to April 30, 2012.

Documentation entry using "notes" in KS AuthentiCare

Providers are expected to use the "notes" field in the KS AuthentiCare web application every time adjustments are made (such as time in/out or activity codes). At a minimum, the following information needs to be included in the note:

- The person requesting the adjustment
- Specifically, what is being adjusted (clock in at 10:35 a.m. added, activity codes for bathing added and toileting removed, etc.)
- Reason for the adjustment (started shopping outside of home, forgot to clock in/out, etc.)
- If the adjustment was confirmed with the member

Signature requirements

The HCBS TA program generally serves minor children under 18 years of age. The parent or legal guardian of the minor member is required to sign the member service plan of care (PSPOC) authorizing waiver services for the minor member. If the member is over 18 years of age, the member or legal guardian with authority to consent medical treatment must sign the PSPOC authorizing waiver services for the member.

HIPAA compliance

As a member in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required during its review and investigation.

Access to records

The provider is required to supply records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844 and 21-3855, inclusive, as amended.

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.

Updated 08/17

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF

- 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 the Kansas Department of Children and Families (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.

PROCEDURES

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 the Kansas Department for Aging and Disability Services (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.
- 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.
- Members or other responsible individuals are informed by the member's MCO 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
  - The need to select and enter into an agreement with an 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 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

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF continued

        - Other situations when the MCO may discontinue the member-direct option and recommend agency-directed services
    - The MCO is responsible for sharing information with the member about member direction of services. The FMS provider 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 MCO 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 the Kansas Department of Health and Environment (KDHE) as the licensing entity. However, DCF is, in practice, currently responsible for licensing functions.

- 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.

Updated 08/17

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF continued

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.

7000. HCBS TA BILLING INSTRUCTIONS Updated 02/26

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~~, through Provider Electronic Solutions (PES),~~ 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.

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

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

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

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

Submission of Claim

Send completed claim and any necessary attachments to:

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

All claims for the following services must be submitted through the Electronic Visit Verification (EVV) system, AuthentiCare Kansas, web application.

• Personal Care Services (self-directed)
• Personal Care Services (agency-directed)*

* Providers have the option to submit services through the EVV system, AuthentiCare.

7010. HCBS TA SPECIFIC BILLING INFORMATION Updated 05/19

Enter diagnosis code R68.89. Enter the appropriate procedure code in Field 24D of the CMS 1500 Claim Form. See the Appendix for an all-inclusive list of HCBS TA waiver codes.

Time keeping
Claims may be submitted for the total amount of actual minutes/hours worked. Claims total may be billed at the end of the billing cycle and rounded to the nearest one-half unit. Unless otherwise specified, one unit is equal to 7.5 through 15 minutes; one-half unit is equal to up to 7 minutes. Providers are responsible for submitting appropriate claims for the amount of services rendered.

Client obligation
The MCO will need to assign the client obligation to the service provider providing the majority of the services. The MCO must inform the provider of the client obligation assignment, and it is the responsibility of the service provider to collect this portion of the cost of service from the member. The provider does not reduce the billed amount on the claim by the client obligation, because the liability will automatically be deducted as claims are processed.
Note: Client obligation is assigned only to HCBS TA services submitted on the POC.

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 Fee-for-Service Provider Manual* for further guidance on the KMAP public or secure website.

Plan of care authorization
The dates of service on the claim must match the dates approved on the POC and cannot overlap. The electronic POC services are prior authorized for one calendar month, beginning on the first and ending on the last day of the month. For example, services billed for May 25 - June 2 of the same year must have separate detail lines for each month (May and June).
Note: The POC is authorized monthly for a period of six months beginning with the month the member is determined eligible for the HCBS TA program. The POC is renewed every six months following eligibility redetermination. Unless otherwise authorized, the amount of services provided to the member must not exceed the amount authorized on the POC and is subject to the daily, monthly, or annual limitations for each specific service.

Same day service
For certain situations, HCBS services approved on a POC and provided on the same day a member is institutionalized may be allowed. Situations are limited to:

- HCBS services provided on the date of admission, if provided prior to admission
- HCBS services provided the date of discharge, if provided following discharge
- MCO care coordination provided 14 days prior to discharge

7030. HCBS TA QUALITY ASSURANCE Updated 09/24

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 participants 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 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)
            - Kansas Modular Medicaid System (KMMS)
            - Medicaid Management Information System (MMIS)
            - Quality Review Tracker (QRT)
            - Kansas Adverse Incident Reporting and Management System (AIRS)

7030. HCBS TA QUALITY ASSURANCE Updated 09/24

HCBS Quality Assurance continued

QA Procedures:

A. KDADS Financial and Information Services Commission (FISC) will select and assign a representative sample of HCBS waiver participants' 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 participant 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 participant's signature;
      b) The use of the participant's signature stamp and/or;
      c) The use of an identified designated signatory.
   3. If a participant 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.

QA Procedures continued

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.

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 Person-Centered Service Plan (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.

7030. HCBS TA QUALITY ASSURANCE Updated 09/24

QA Procedures continued:

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 participant 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. Participant 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.

7030. HCBS TA QUALITY ASSURANCE Updated 09/24

QA Procedures continued

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], Brain Injury [BI]);
      b) HCBS LOC Review: Required Documentation for QA Reviews (Autism [AU]);
      c) HCBS LOC Review: Required Documentation for QA Reviews (Intellectual/Developmental Disability [IDD]);
      d) HCBS LOC Review: Required Documentation for QA Reviews (Technology Assisted [TA]);
      e) HCBS LOC Review: Required Documentation for QA Reviews (Severe Emotional Disability [SED])
      f) HCBS MCO Record Review: Required Documentation for QA Reviews (Except SED);
      g) HCBS MCO LOC and Record Review: Required Documentation for SED QA Reviews;
      h) 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.

Documentation continued

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 participant 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/Registered Nurse (RN) Statement (if applicable);
      d) Legal representative, DPOA, and/or guardianship paperwork
      e) Physical exam;
      f) Evidence of rights and responsibilities discussed with participant and/or representative/guardian;
      g) Evidence of appeal and grievance rights/processes discussed with participant 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);
      j) BI Waiver only - Progress notes for Transitional Living Skills and/or Therapies.
      k) SED Only: Documentation on Critical Incidents/APS/CPS reports regarding restraints, seclusion, or other restrictive interventions and/or anything in the AIR system.

7040. HCBS TA ELECTRONIC VISIT VERIFICATION Updated 01/25

Effective February 6, 2025, AuthentiCare will become the sole approved claims entry point for services that require Electronic Visit Verification (EVV). Initial Claims for EVV covered services that are not received from AuthentiCare will be denied. Claims will be created from AuthentiCare to cover all services, excluding WORK and STEPS that require EVV.

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.

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.

7040. HCBS TA ELECTRONIC VISIT VERIFICATION Updated 09/25

Ordering Provider Responsibilities
MCOs must ensure that all authorizations for HCBS subject to EVV include the appropriate ordering provider information, regardless of provider type (05 or 55).

MCOs must include the ordering provider's first name, last name and National Provider Identifier (NPI) from CMS Form 485 (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.

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.

The following HCBS codes require an ordering provider on the EVV authorization:

Waiver	Service	Code	EVV Code
Technology Assisted	Specialized Medical Care	T1000	TAT1000
Technology Assisted	Health Maintenance Monitoring	T1001	TAT1001
Technology Assisted	Intermittent Intensive Med	T1002	TAT1002
Technology Assisted	Agency Directed PCS	T1004	HCTAT1004
Technology Assisted	Medical Respite	T1005	TAT1005

Claims Adjustments
Providers may continue to submit claims adjustments through the provider portal. Ensure all required documentation and corrections are submitted timely.

8100. COPAYMENT Issued 08/08

HCBS TA program waiver services are exempt from copayment requirements.

8300. BENEFIT PLANS Updated 11/17

A KMAP member is assigned to one or more KMAP benefit plans. These benefit plans entitle the member to certain services. See **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for complete information on the State of Kansas Medical Card and eligibility verification.

8400. MEDICAID Updated 05/19

HCBS TA Waiver Program
All HCBS TA waiver program services require prior authorization through the POC process. Services furnished to a member who is institutionalized are not reimbursable.

8400. MEDICAID Updated 05/19

Health Maintenance Monitoring
Procedure code: T1001

Health Maintenance Monitoring (HMM) is provided in conjunction with agency-directed or self-directed Personal Care Services to provide ongoing evaluation and oversight of the member's health and welfare status. This service is intended to ensure the member's medical needs are being met when his or her healthcare is being managed by a nonlicensed agency or self-directed worker. Specifically, the service to be provided includes, but is not limited to, the following:

- Provide general healthcare assessment
- Assess vital signs
- Evaluate healthcare management activities
- Ensure appropriate medication administration
- Consult with the member or parent/legal guardian regarding assessment and general healthcare status
- Report assessment findings to the MCO care coordinator per program protocol
- May include delegation or supervision of KDADS-approved health maintenance activities in accordance with the Nurse Practice Act

The MCO coordinates and communicates the effective date of service through the Notice of Action (NOA). The member can select his or her provider of choice, and services can begin upon receipt of an NOA or an approved POC on KMMS.

HMM can be provided in all customary and usual community locations, including where the member resides and socializes.

HMM requires prior authorization by the program manager or a designee at KDADS.

Documentation requirements

- Physician's order to assess and monitor the current and ongoing healthcare status
- NOA to initiate service and establish the scope and frequency of the service to be delivered
- Location where service is provided
- Service provider's printed or typed name and signature
- Member's printed or typed full name, identification number, and demographic information
- Dates of service, beginning and ending (with MM/DD/YY)
- Start and stop times for each visit, including AM/PM or using 2400 clock hours
- Sources of information, such as family members, legal representatives, service providers, and other interested parties
- Necessary details to meet federal and state requirements

Documentation must be legible, accurate, and timely. Time spent must be clearly documented in the notes. Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable. Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed. Providers are responsible to ensure that the service was provided prior to submitting claims.

Health Maintenance Monitoring continued

Limitations

- Service is limited to one unit per quarter (every three months). One unit is equal to one visit.
- This service cannot be provided in conjunction with or overlap with Intermittent Intensive Medical Care (T1002), Specialized Medical Care (T1000), Medical Respite (T1005), or other State Plan services.
- This service cannot be provided by a parent or legal guardian authorized to provide reimbursable service under the Professional Service under Defined Conditions (PSUDC) agreement.

Reimbursement

- Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the plan of care (POC).
- Payment for HMM cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- The cost of transportation to and from the member's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of this service.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for intellectual and developmental disability (ICF/IDD), or institution for IDD (I/IDD) are not reimbursable.

Provider requirements

- Be an employee of a KMAP-enrolled public health agency or be a licensed home health agency (HHA) provider authorized to provide services under the HCBS TA waiver program
  Note: Licensed HHA employees must meet the licensing standards as regulated by KDHE as specified in K.S.A. 65-5101 through K.S.A. 65-5117
- Be a RN or LPN
- Hold a current license issued by the Kansas State Board of Nursing (KSBN) in accordance with K.S.A. 65-1113
- Have a minimum of two years nursing experience in working with individuals with special health care needs
- Maintain all standards, certifications, and licenses required for the specific professional field through which the service is provided including, but not limited to:
  - Professional license/certification
  - Adherence to Disability Behavioral Health Services (DBHS)/Community Supports & Services (CSS) training and professional development requirements
  - Maintenance of clear background as evidenced through the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), KSBN, and Department of Motor Vehicles (DMV)

Note: Applicant must meet provider requirements and receive approval by KDADS to provide HCBS TA Health Maintenance Monitoring.

8400. MEDICAID Updated 11/17

Intermittent Intensive Medical Care
Procedure code: T1002

Intermittent Intensive Medical Care (IIMC) is provided by an RN only. IIMC is designed to meet the member's intermittent skilled nursing needs when he or she has chosen to meet his or her routine health maintenance care needs with an attendant level of care. It is designed to provide the member with an additional service choice to meet specific skilled nursing care needs that cannot be performed by a personal care services worker. This service is intermittent and must be identified as a medically necessary service in the level of care assessment instrument. These specific nursing care elements are identified in the hydration/specialty care section of the MATLOC assessment which include but are not limited to the following:

- Intravenous (IV) therapy administered less than every four hours daily
- IV therapy intermittent to be delivered less than four hours per day, weekly or monthly
- Total parenteral nutrition (TPN) central line delivered less than four hours daily
- Blood product administered less than four hours, intermittently, weekly or monthly
- IV pain control less than four hours daily
- Lab draw each peripheral
- Lab draw each central
- Chemotherapy IV or injection
- Home dialysis administration

Services provided under IIMC must be authorized and managed by a licensed healthcare provider (physician, physician assistant [PA], ARNP) who has determined the service is medically appropriate and necessary in managing the Member's healthcare needs. This service is coordinated and monitored by the MCO care coordinator. The member can select his or her provider of choice to deliver the needed care. IIMC can be provided in all customary and usual community locations, including where the member resides and socializes.

IIMC requires prior authorization by the program manager or a designee at KDADS.

Documentation requirements

- Documentation of signed order from licensed healthcare provider (physician, PA, ARNP) authorizing service(s)
- Notice of Action from member's MCO care coordinator to implement service detailing type of service, scope, and frequency of service to be delivered
- Location where service is provided
- Service provider's printed or typed name and signature
- Member's printed or typed full name, identification number, and demographic information
- Date of service (beginning and ending with MM/DD/YY)
- Start and stop time for each visit, including AM/PM or using 2400 clock hours

Documentation must be legible, accurate, and timely. Time spent must be clearly documented in the notes. Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable. Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed. Documentation must provide the necessary detail to meet federal

Intermittent Intensive Medical Care continued

and state requirements. Providers are responsible to ensure that the service was provided prior to submitting claims.

Limitations

- IIMC can be provided up to four hours per day, not to exceed 14 days per month.
- This service is not designed for medical needs identified as requiring more than four hours of nursing intervention. While assessing the level of care needed, the MCO care coordinator will determine and coordinate the most appropriate service to meet the medical needs of the member.
- This service cannot be provided in conjunction with or overlap with Health Maintenance Monitoring (T1001), Specialized Medical Care (T1000), or Medical Respite (T1005).
- The service can be provided in conjunction with agency or self-directed Personal Care Services.

Reimbursement

- Payment for IIMC cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- IIMC does not duplicate any other Medicaid state plan service or other services available to the member at no cost.
- Providers of this service are reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, ICF/IDD, or I/IDD are not reimbursable.

Provider requirements

- Be an employee of a KMAP-enrolled public health agency or be a licensed HHA provider authorized to provide services under the HCBS TA waiver program
  Note: Licensed HHA employees must meet the licensing standards as regulated by KDHE as specified in K.S.A. 65-5101 through K.S.A. 65-5117.
- Be a licensed RN
- Hold a current license granted by KSBN to practice in the capacity of a nurse in Kansas
- Must maintain all standards, certifications and licenses required for the specific professional field through which service is provided including, but not limited to:
  - Professional license/certification
  - Adherence to DBHS/CSS training and professional development requirements
  - Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV

Note: Applicant must meet provider requirements and receive approval by KDADS to provide HCBS TA ICCM.

8400. MEDICAID Updated 05/19

Specialized Medical Care
Procedure code: T1000 – Registered Nurse (RN) and Licensed Practical Nurse (LPN)

This service provides long-term nursing support for medically fragile and technology-dependent members. The required level of care must provide medical support for members needing ongoing, daily care as in a hospital. The service is to effectively address the intensive medical needs of the member and prevent hospitalization or the need for long-term hospitalization so that the member can choose to live in the community.

For the purpose of this waiver, a provider of Specialized Medical Care must be a RN or LPN under the supervision of a RN. Providers must be trained to deliver skilled nursing services as identified in the POC and within the scope of the State's Nurse Practice Act. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of members.

- The service may be provided in all customary and usual community locations including where the member resides and socializes.
- It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the members.
- Specialized Medical Care does not duplicate any other Medicaid state plan service or other services available to the member at no cost.
- The medical necessity of this service is subject to the nursing acuity assessment as identified in the MATLOC instrument and the Individual/Family Needs Assessment used in the development of the member's POC.
- Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.

Documentation requirements

- Documentation must encompass information provided in the MATLOC instrument and the Individual/Family Needs Assessment that was used to develop the member's POC.
- Documentation must include information about the access, appropriateness, and coordination of services.
- Sources of information can include contacts with the member, family members, legal representatives, service providers, and other interested parties.
- Documentation must provide the necessary detail to meet federal and state requirements.
- Documentation must be legible, accurate and timely.
  Note: Member's files may be used for supervisory reviews, home care review audits, QA reviews, and issues related to client obligations.
- Documentation, at a minimum, must include the following:
  - Initial assessment and reassessment relative to the nursing POC
  - Authorization of medically necessary waiver services signed by physician or medical provider
  - Changes in the member's medical status or care
  - Services being used and provided
  - Service provider's printed or typed name and signature
  - Location where service is provided
  - Member's printed or typed full name, identification number, and demographic information

Specialized Medical Care continued

- Date of service (beginning and ending with MM/DD/YY)
- Signature of parent or legal guardian with the authority to provide consent to receive services
- Start and stop times, including AM/PM or using 2400 clock hours

- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable.

Limitations

- Providers of this service cannot provide other Personal Care Services to members for whom they provide Specialized Medical Care.
- Specialized Medical Care provided by an entity under the Professional Services Under Defined Conditions (PSUDC) agreement cannot provide Medical Respite.
- Providers of Specialized Medical Care are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a HHA licensed by KDHE.
- A parent/legal guardian who provides Specialized Medical Care services under professional services under the defined condition is limited to 8 hours per day, not to exceed 40 hours per week. The need to exceed limits are subject to assessed needs and must be prior authorized.
- The cost of transportation to and from the member's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of this service.
- The majority of contacts must occur in customary and usual community locations where the member lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, ICF/IDD, or I/IDD are not reimbursable.
- This service may begin upon approval of HCBS TA waiver program and services.
- The MCO will coordinate and communicate the effective date of service.

Reimbursement

- Payment for Specialized Medical Care cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- Specialized Medical Care (T1000) cannot be billed or reimbursed concurrently on the same day with Medical Respite (T1005).

Provider requirements

- Be an employee of a KMAP-enrolled provider authorized to provide services under the HCBS TA waiver program
- Be an RN or LPN
- Hold a current license granted by KSBN to practice in the capacity of a nurse in Kansas

8400. MEDICAID Updated 05/19

Specialized Medical Care continued

- Must maintain all standards, certifications and licenses required for the specific professional field through which service is provided including, but not limited to:
    - Professional license/certification
    - Adherence to KDADS training and professional development requirements
    - Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV
- Must meet the licensing standards as regulated by KDHE as specified in K.S.A. 65-5101 through K.S.A. 65-5117

Note: Applicant must meet provider requirements and receive approval by KDADS to provide HCBS TA Specialized Medical Care.

8400. MEDICAID Updated 05/19

Personal Care Services Worker

Procedure codes:
T1004 Personal care services worker – agency-directed
T1019 Personal care services worker – self-directed

Personal Care Services are available to members who choose to remain in their home while living with their medical limitations. These services provide necessary assistance for members both in their home and community.

Personal care services workers ensure the health and welfare of the member while supporting him or her with tasks normally done by a parent, legal guardian, or caretaker. They assist the member in performing these tasks to promote independence, productivity, and integration.

The functions of a personal care services worker include but are not limited to assisting with:

- Activities of daily living (ADLs)
    - Bathing
    - Grooming
    - Toileting
    - Transferring
- Health maintenance activities
    - Extension of therapies
    - Feeding
    - Mobility and exercises
    - Socialization
    - Recreation activities

Note: The personal care services worker supports the member in accessing medical services and normal daily activities by accompanying or providing transportation to accomplish tasks as listed within the scope of service.

Agency-directed Personal Care Services will be coordinated by the KanCare MCO case manager and submitted in the electronic POC for prior authorization and approval.

Self-directed Personal Care Services will be arranged for, and purchased under, the member's or legally responsible party's written authority. They will be paid through an enrolled fiscal agent consistent with and not to exceed the member's POC.

Members are permitted to choose qualified provider(s) who have passed the required background checks.

The member or legally responsible individual with the authority to direct services can at any point determine to no longer self-direct and can instead receive previously approved waiver services, without penalty.

8400. MEDICAID Updated 05/19

Personal Care Services Worker continued

Documentation requirements

- Documentation must encompass information provided in the MATLOC instrument and the Individual/Family Needs Assessment that was used to develop the member's POC related to the service being provided.
- Documentation must include information about the access, appropriateness, and coordination of personal care services.
- Sources of information can include contacts with the member, family members, legal representatives, service providers, and other interested parties.
- Documentation must provide the necessary detail to meet federal and state requirements.
- Documentation must be legible, accurate, and timely.
  Note: Member's files may be used for supervisory reviews, home care review audits, QA reviews, and issues related to client obligations.
- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time-period of the billing cycle. Documentation generated after this time is not acceptable.

Personal Care Services - Agency-directed

Documentation, at a minimum, must include the following:

- Initial assessment and reassessment relative to the nursing POC
- Authorization of medically necessary waiver services signed by physician or medical provider
- MATLOC signed by the physician or medical provider
- Notice of Action detailing the type of service, scope, frequency, and duration of services to be provided
- Changes in the member's medical status or care
- Services being used and provided
- Service provider's printed or typed name and signature
- Location of service provided
- Member's printed or typed full name, identification number and demographic information
- Date of service (beginning and ending with MM/DD/YY)
- Signature of parent or legal guardian with the authority to provide consent to receive services
- Start and stop times for each visit, including AM/PM or using 2400 clock hours

Providers billing Personal Care Services (agency directed) may use the Electronic Visit Verification (EVV) system, AuthentiCare.

For Supported Employment Services, documentation is required for services provided and billed to KMAP and must be collected either using the EVV system, AuthentiCare Kansas or in writing. Electronic visit verification documentation must, at a minimum, include the following:

Personal Care Services Worker continued

- Identification of the waiver service being provided
- Identification of the member receiving the service (first and last name)
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (such as Self-Directed Enhanced Care Services)
- Member's name (first and last) and signature on each page of documentation (see Signature Limitations)
- Worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)

Personal Care Services - self-directed

Documentation, at a minimum, must include the following:

- MATLOC signed by the physician or medical provider
- Notice of Action detailing the type of service, scope, frequency, and duration of services to be provided
- Completed Skill Checklist demonstrating delegation and training provided and signed by the member or parent/legal guardian
- Documentation of changes in the member's medical status or care
- Service provider's printed or typed name and signature
- Location of service provided
- Member's printed or typed full name, identification number and demographic information
- Date of service (beginning and ending with MM/DD/YY)
- Signature of parent or legal guardian with the authority to provide consent to receive services
- Start and stop times for each visit, including AM/PM or using 2400 clock hours

Note: Personal Care Services (self-directed) providers are required to document time and attendance through the EV&M system of KS AuthentiCare in lieu of paper timesheets. See additional information under the **Introduction to the HCBS TA program** section of this manual.

Limitations

- A personal care services worker cannot perform any duties not delegated by the individual with the authority to direct services or duties as approved by the member's physician. A service or duty must be identified as a necessary task in the POC.
- The parent or legal guardian of the minor member cannot be his or her personal care services worker.
- Personal Care Services are limited to 372 hours or 1488 units per month per member. One unit is equal to 15 minutes.
- Personal Care Services can be provided up to a maximum of 12 hours or 48 units per day.

Personal Care Services Worker continued

- It is the expectation that members needing assistance with ADL tasks who live with a parent or guardian capable of performing these tasks will rely on this informal, natural support for this assistance. Otherwise, there must be extenuating, or specific circumstances documented in the POC. As such, personal care services workers should not assist with the following:
  - Lawn care
  - Snow removal
  - Shopping
  - Ordinary housekeeping (which should be done along with the household responsibilities of those living with the member)
  - Meal preparation (during the times when normal meal preparation occurs in the household)
- The majority of contacts must occur in customary and usual community locations where the member lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, ICF/IDD, or I/IDD are not reimbursable.
- The cost of transportation to and from the member's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of these services.

Reimbursement

Payment for a personal care services worker may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider requirements

Providers must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including, but not limited to:

- Professional license/certification
- Adherence to DBHS/CSS training and professional development requirements
- Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV

Personal care services worker – agency-directed

- Have a high school diploma or equivalent
- Be 18 years of age or older
- Meet the agency's qualifications
- Reside outside of the member's home
- Complete training and pass certification as regulated under K.A.R. 28-39-165 or 28-51-100 by the State of Kansas licensing agency
- Be employed by and under the direct supervision of a HHA licensed by KDHE, enrolled as a KMAP provider authorized to provide services under the HCBS TA waiver program
- Meet the skill training documentation required by KDADS

Personal care services worker – self-directed

- Have a high school diploma or equivalent
- Be 18 years of age or older
- Reside outside of the member's home

Personal Care Services Worker continued

- Sign an agreement with a Medicaid-enrolled FMS provider, acting as an administrative agent on behalf of the member
- Complete the necessary skill training needed to care for the member as recommended by the parent or legal representative and qualified medical provider
- Be a KMAP-enrolled provider authorized to provide HCBS TA waiver program services
- Meet the skill training documentation required by KDADS

All payments for personal care services worker (self-directed) care will be arranged by an FMS provider with the member's or parent/legal guardian's written authorization of the purchase. The member will have complete access to choose any qualified FMS provider. The provider must meet the qualifications as specified in the *HCBS FMS Fee-for-Service Provider Manual*. Each individual qualified provider will not be given a separate provider agreement but may choose to contract with any qualified provider agency or through an FMS agency.

Providers of these services must meet all standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to:

- Professional license/certification
- Adherence to DBHS/CSS training and professional development requirements
- Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN and DMV

8400. MEDICAID Updated 11/17

Medical Respite
Procedure code: T1005

Medical respite is a temporary service provided on an intermittent basis to provide the member's family short, specified periods of relief. Medical respite must be provided in the member's place of residence. It serves the family by:

- Meeting nonemergency or emergency family needs
- Restoring or maintaining the physical and mental well-being of the member and/or his or her family
- Providing supervision, companionship, and personal care to the member

Documentation requirements

- Documentation must encompass information provided in the MATLOC instrument and the Individual/Family Needs Assessment that was used to develop the member's POC.
- Documentation must include information about the access, appropriateness, and coordination of services.
- Sources of information can include contacts with the member, family members, legal representatives, service providers, and other interested parties.
- Documentation must provide the necessary detail to meet federal and state requirements.
- Documentation must be legible, accurate, and timely.
  Note: Member's files may be used for supervisory reviews, home care review audits, QA reviews, and issues related to client obligations.
- Documentation, at a minimum, must include the following:
  - Initial assessment and reassessment relative to the nursing POC
  - Authorization of medically necessary waiver services signed by physician or medical provider
  - Changes in the member's medical status or care
  - Services being used and provided
  - Service provider's printed or typed name and signature
  - Location of service provided
  - Member's printed or typed full name, identification number and demographic information
  - Date of service (beginning and ending with MM/DD/YY)
  - Signature of parent or legal guardian with the authority to provide consent to receive services
  - Start and stop times for each visit, including AM/PM or using 2400 clock hours
- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable.

Limitations

- Providers of Medical Respite are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a HHA licensed by KDHE.

Medical Respite continued

- Medical Respite is limited to 168 hours or 672 units per calendar year.
- The cost of transportation to and from the member's place of residence and other service sites or places in the community is included in the reimbursement rate paid to the providers of this service.
- The majority of contacts must occur in customary and usual community locations where the member lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, ICF/IDD, or I/IDD are not covered.

Reimbursement

- Payment for Medical Respite cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- Medical Respite (T1005) cannot be billed or reimbursed concurrently on the same day with Specialized Medical Care (T1000).
- Medical Respite provided by an entity under the PSUDC agreement is not reimbursable.

Provider requirements

- Be an employee of a KMAP-enrolled provider authorized to provide services under the HCBS TA waiver program
- Be a RN or LPN
- Hold a current license granted by KSBN to practice in the capacity of a nurse in Kansas
- Maintain all standards, certifications and licenses required for the specific professional field through which service is provided including, but not limited to:
    - Professional license/certification
    - Adherence to KDADS training and professional development requirements
    - Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV
- Meet the licensing standards as regulated by KDHE as specified in K.S.A. 65-5101 through K.S.A. 65-5117

8400. MEDICAID Updated 05/19

Home Modification
Procedure code: S5165

For the purpose of the HCBS TA waiver program, home modification services are defined as modifications or adaptations to the member's home through tangible equipment or hardware, such as adaptive equipment or environmental modifications. The need for a home modification must be identified as necessary to assist the member in day-to-day functions as indicated in the individualized POC. The goal is to assist members in supporting their independence, mobility, and productivity in the community.

Documentation Requirements

- Documentation must be completed at the time the service is provided and encompass information provided in the MATLOC instrument and the Individual/Family Needs Assessment that was used to develop the member's POC.
- Documentation must include information about the access, appropriateness, and coordination of services.
- Sources of information can include contacts with the member, family members, legal representatives, service providers, and other interested parties.
- Documentation must provide the necessary detail to meet federal and state requirements.
- Documentation must be legible, accurate, and timely.
  Note: Member's files may be used for supervisory reviews, home care review audits, QA reviews, and issues related to client obligations.
- Documentation, at a minimum, must include the following:
  - Printed or typed name of business or contractor
  - Member's printed or typed full name
  - Printed or typed name and signature of parent, legal guardian, or designated signatory
  - Identification of the technology or service being provided
  - Date of service (beginning and ending with MM/DD/YY)
  - Amount of purchase
  - Statement of inspection by provider to ensure that the product was purchased and/or installed as authorized
- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable.

Covered Services

- Purchase or rental of new or used member transfer lift
- Purchase of or installation of ramp not covered by any other resources
- Widening of doorways
- Modifications to bathroom facilities owned by the member, parent, or legally responsible party where the member resides
- Modifications related to the approved installation of modified ramps, doorways or bathroom facilities

Home Modification continued

Limitations

- Services must be provided within specified local and state building codes.
- Modifications are made within the existing structures and must not result in addition of square footage to the existing structure.
- Home modification services are reimbursed at one unit equal to one purchase, limited to a lifetime maximum of $10,000.
- All services provided must meet the local city and state building codes.
- The property must be owned by the member or his or her parent/legal guardian and occupied by the member.
- Home modification needs are assessed by the MCO case manager, using the MATLOC instrument. The MCO case manager and the member or parent/legal guardian must obtain and submit to KDADS two bids for the equipment or modification according to policy guidelines.
- The cost of transportation to and from the member's place of residence and other service sites or places in the community is included in the reimbursement rate paid to the providers of this service.
- The majority of contacts must occur in customary and usual community locations where the member lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, ICF/IDD, or I/IDD are not covered.

Reimbursement

To avoid any overlap of services, Home Modification is limited to those services not covered through the regular state plan.

Provider Requirements

- The provider must be a licensed contractor/durable medical equipment (DME) provider eligible to provide home modification or adaptation services.
- Services will be arranged by the MCO case manager and reimbursed through Medicaid with the written authorization of the member or parent/legal guardian for the purchase.
- The member has the opportunity to choose any qualified provider (agency or individual).
- In order to provide services, the individually qualified provider can contract directly with Medicaid or choose to contract with any qualified provider agency.
- Providers must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including, but not limited to:
    - Professional license/certification
    - Adherence to DBHS/CSS training and professional development requirement
    - Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV

Note: An exception of certification or licensure requirement can be granted with a letter from the city or county of the member's residence declaring certification or licensure is not required.

8400. MEDICAID Updated 07/25

IMPLEMENTATION OF VIRTUAL DELIVERY OF SERVICES
Effective with dates of service on or after July 1, 2025, Virtual Delivery of Services (VDS) will be authorized across all HCBS Waivers. This new policy establishes the option for certain services to be provided electronically using a HIPAA-compliant, real-time audiovisual platform that enables staff to both see and hear the participant. This initiative supports greater autonomy, access, and flexibility for individuals receiving services, while maintaining compliance with federal privacy and safety requirements.

Definition:
VDS refers to the real-time provision of supports using secure audiovisual technology. Communication methods such as text messaging or email do not qualify as VDS under this policy and will not be considered direct service delivery.

Place of Service Codes:
- **Code 02:** VDS provided outside the participant's home
- **Code 10:** VDS provided within the participant's home

Place of service must be documented in the participant's Person-Centered Service Plan (PCSP).

Authorized Service and Applicable Code:

Service	KMAP Codes
Personal Care Services - Agency	T1004

Key Policy Considerations:
- **Informed Consent:** Participants or their legal representatives must sign a consent form confirming the choice between in-person and virtual service delivery, including a discussion of any potential health or safety concerns.
- **Hands-On Services:** VDS is not permitted for services requiring physical assistance.
- **Participant Choice:** VDS should not replace or discourage in-person services. Participants may switch to in-person services at any time; transition must occur within 7 days, or immediately if health/safety concerns arise.
- **Privacy:** Virtual service platforms must uphold participant privacy. Use of cameras in private spaces such as bathrooms and bedrooms is prohibited.
- **HIPAA Compliance:** All VDS must adhere to HIPAA Privacy and Security Rules.
- **Support for Technology Use:** Participants' need for assistance with VDS technology must be assessed and documented in the PCSP.
- **Service Frequency and Visit Modality:** Decisions regarding the extent and frequency of VDS, including any required in-person visits, will be determined and documented in the PCSP.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS TA SERVICES

Updated 08/24

KDADS has established an adverse incident reporting and management system in accordance with the statutory requirements under 1915 (c) of the Social Security Act and the health and welfare waiver assurance and associated sub-assurances.

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.

I. 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 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 HCBS waiver services 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. Training materials shall be provided on site and on the KDADS website.

II. Adverse Incident Definitions

A. **Abuse:** Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a member, including:
    1. Infliction of physical or mental injury.
    2. Any sexual act with a member that does not consent or when the other person knows or should know that the member is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship.
    3. Unreasonable use of a physical restraint, isolation, or medication that harms or is likely to harm the member

4. Unreasonable use of a physical or chemical restraint, medication, or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the member or another individual.
5. A threat or menacing conduct directed toward the member that results or might reasonably be expected to result in fear or emotional or mental distress to the member
6. Fiduciary abuse
7. Omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness

B. **Chemical Restraint**: Any medication used to control behavior or to restrict the member's freedom of movement and is not a standard treatment for the member's medical or psychiatric condition.
C. **Death:** Cessation of a member's life.
D. **Elopement:** The unplanned departure from a unit or facility where the member leaves without prior notification or permission if there is a documented concern for safety in the community.
E. **Emergency Medical Care:** Inpatient or outpatient emergency medical services that are necessary to ensure the health and welfare of the member which require use of the most accessible medical facility.
F. **Exploitation:** Misappropriation of the member's property or intentionally taking unfair advantage of a member's physical or financial resources for another individual's personal or financial gain by the use of undue influence, coercion, harassment, duress, deception, false representation, or pretense by a caretaker or another person.
G. **Fiduciary Abuse:** A situation in which any person who is the caretaker of, or who stands in a position of trust to, a member, takes, secretes, or appropriates their money or property to any use or purpose not in the due and lawful execution of such person's trust or benefit.
H. **Law Enforcement Involvement:** Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes, and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.
I. **Misuse of Medications:** The incorrect administration or mismanagement of medication by someone providing HCBS which results in or could result in serious injury or illness to a member.
J. **Natural Disaster:** A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented, and reported as required by the policy in the AIR system. A separate AIR report shall be made for all HCBS members in the area who are impacted by the natural disaster.
K. **Neglect:** The failure or omission by a caretaker, or another person with a duty to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
L. **Physical Restraint**: Any manual method of physical object or device attached or adjacent to a member's body that restricts the member's freedom of movement.
M. **Seclusion:** The involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving.

N. **Self-Neglect:** The failure or omission by oneself to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
P. **Serious Injury:** An unexpected occurrence involving the significant impairment of the physical condition of a member. Serious injury specifically includes loss of limb or function.
Q. **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
R. **Suicide Attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

III. Adverse Incident Reporting Requirements

A. Reporting Abuse, Neglect, Exploitation (ANE), and Fiduciary Abuse.
    1. ANE and Fiduciary Abuse shall be reported to DCF as required by K.S.A. 39-1431, K.S.A. 38-2223.
    2. ANE and Fiduciary Abuse reported to DCF shall also be reported to KDADS. When ANE and Fiduciary Abuse is reported to KDADS, the report shall identify the date of report to DCF and the intake number.
    3. ANE and Fiduciary Abuse reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
    4. ANE and Fiduciary Abuse reports require KDADS confirmation before final resolution. KDADS shall verify the following:
        a) A preventable cause was accurately identified; and
        b) The MCO observed appropriate follow-up measures.
    5. The MCO investigation shall verify the following:
        a) That appropriate follow-up actions are taken against the alleged perpetrator to minimize the risk of reoccurrence; and
        b) That appropriate supports are in place to assist the alleged victim to address any concerns they may have as a result of the occurrence.
B. Reporting Seclusion, Physical Restraint and Chemical Restraint
    1. Seclusion, Physical Restraint, and Chemical Restraint reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
    2. Seclusion, Physical Restraint, and Chemical Restraint reports shall require KDADS confirmation before final resolution. KDADS confirmation process shall examine if:
        a) The intervention was authorized or unauthorized; and
        b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.

3. The MCO investigation shall verify that:
    a) The application of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, complied with the procedures specified in the approved waiver; and
    b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.
4. Chemical Restraint Reporting: The requirement for reporting chemical restraints is to provide tracking and trending data to ensure the health and welfare of the member. Follow-up measures shall verify that the necessary supports are in place for the member.
    a) Authorized Use of Chemical Restraint: Authorized use of chemical restraint is defined as the administration of any medication which follows the member's current Person-Centered Service Plan (PCSP).
        i. The medication must be prescribed and approved by a licensed healthcare provider.
        ii. The approved use must comply with the policy established per the setting.
        iii. Medication administration must follow the member's PCSP.
        iv. Any prescribed medication with the intended purpose of altering a member's behavior as warranted by the current situation. A report is required when a prescribed medication is administered on an interval beyond or at a dosage above the routinely scheduled regimen as documented in the member's PCSP.
    b) Unauthorized Use of Chemical Restraint: Unauthorized use of chemical restraint is defined as the administration of any medication that is not authorized for use in the member's current PCSP.
        i. A report must be filed whenever medication is administered as a chemical restraint, as defined above, regardless of whether it is prescribed or over the counter. No reporting is necessary if the medication is administered within the confines of its prescription and is not used as a chemical restraint.

C. Reporting Death
1. Death reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
2. Death reports require KDADS confirmation before final resolution. KDADS shall verify the following:
    a) The deceased's expectancy of death was accurately reported.
    b) The deceased's hospice status was accurately reported.
    c) Any preventable cause was accurately identified; and
    d) The MCO observed appropriate follow-up measures.
3. The MCO investigation shall verify:
    a) If the death was expected or unexpected.
    b) If there was a preventable cause of death; and
    c) If the deceased was a recipient of hospice, then the MCO shall verify supporting documents in the form of a physician's order or hospice admission documentation.

D. Reporting of All Other Adverse Incidents
    1. 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.

Military Inclusion
Active duty or honorably discharged military personnel and/or immediate family members are permitted to bypass the waitlist for HCBS programs in acknowledgment of their dedication and service to the United States of America.

I. Policy

A. KDADS determines HCBS waiver program eligibility for all HCBS waivers in the State of Kansas.
    1. Each current and approved HCBS waiver program has reserved capacity for active or honorably discharged military personnel and/or immediate family members.

B. Active or honorably discharged eligible military personnel and/or immediate family members (eligible dependents) may bypass the HCBS program waitlists, and access services, if the following criteria are met:
    1. The military personnel must show proof of active-duty service or an honorable discharge.
        a) Proof of active service or honorable discharge shall be any of the following:
            i. Most recent copy of Leave and Earning Statement (LES)
            ii. Valid Military Identification Card
            iii. Certificate of Release or Discharge from Active Duty (Form DD-214)
    2. The military personnel, or eligible dependent, must present documentation showing proof of:
        a) Coverage under Tricare Extended Care Health Option (ECHO) during the time of military service; or
        b) Coverage under Tricare Extended Care Health Option (ECHO) at the time of separation from active military service.
    3. Be a Kansas resident, by maintaining or demonstrating the intent to make Kansas the principal place of residency, consistent with K.S.A.79-39,109 and K.A.R. 95-12-4a.
        a) Evidence supporting residency or demonstrating the intent to establish residency, may include, but is not limited to, the following:
            i. Proof eligible military personnel is registered to vote in Kansas
            ii. Proof eligible military personnel has filed a Kansas resident income tax return for the most recent taxable year
            iii. Proof eligible military personnel have current motor vehicle registration in Kansas
            iv. Proof eligible military personnel hold a current valid Kansas driver's license or non-driver identification card
    4. A dependent of military personnel residing in the state of Kansas may qualify for military inclusion exception.
        a) A qualifying dependent must meet the criteria for dependency as defined by the Internal Revenue Service (IRS).

b) Evidence supporting dependency may include, but is not limited to, the following:
   i. Recent tax return
   ii. Marriage license
   iii. Birth certificate
   iv. Court order
   v. Adoption documentation

5. The eligible military personnel or their eligible dependent must meet the functional eligibility, program eligibility, and financial eligibility requirements for the HCBS waiver program that they have requested.
   a) Financial eligibility for all HCBS waiver programs is determined by the KDHE.

II. Procedures

A. Functional Eligibility Determination
   1. If an active or honorably discharged military personnel and/or their dependent is referred to an assessing entity for functional assessment, and if the individual requests an exception based on military inclusion, the assessor shall collect the proof of the following:
      a) Kansas residency
      b) Military member's or dependent's Tricare Echo Verification Documentation, and
      c) Proof of active-duty service through documentation (such as Form DD-214)
      d) Proof of dependency on qualified military personnel (when applicable)

B. Applicant shall provide required supporting proof of military service to the assessing entity at the time of functional assessment:
   1. If such documentation is not available at the time of functional assessment, the assessor shall proceed with completing a functional assessment based upon applicable current/approved waiver program requirements, policy, and procedures.
      a) Supporting proof of military service must be provided to the state's designated system of record no later than five days after the functional assessment to be considered for inclusion exception during program eligibility determination.
      b) The assessor must notify the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception.

C. For individuals separating from active-duty military service:
   1. A functional assessment must be completed within 30 days of termination of active duty or separation from military service to be considered for the military inclusion exception.
   2. If an individual meets the functional eligibility but fails to meet the requirements for a military inclusion exception, then the individual may:
      a) Access an HCBS program in the same manner as any other applicant found functionally eligible; or
      b) Be placed on the appropriate waitlist as of the date of functional eligibility if the qualifying HCBS program has a waitlist.

D. After validating the proof of military service and determining that an eligible military personnel or eligible dependent meets the requested HCBS waiver functional eligibility criteria:

1. The assessor shall follow functional assessment and waiver eligibility procedures of the relevant HCBS waiver program.
    a) The assessor shall notify, using the state-designated communication method, the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception listed in the Section I of this policy.
2. KDADS may request the supporting documentation proving eligibility for military inclusion exception from the assessor, or directly from the individual deemed eligible for military inclusion exception to support a program eligibility determination.

E. If the assessor determines the individual seeking military inclusion exception for themselves or their dependent is not functionally eligible for the HCBS waiver program:
    1. The assessor shall follow waiver policies and procedures applicable to the waiver program that the applicant has applied.
    2. The assessor shall counsel the applicant on alternative community options and services, including services available through the Veterans Affairs (VA) Administration.

III. Documentation

A. KDADS HCBS Program Manager shall follow established current/approved HCBS waivers, policy, and procedures in requesting and responding to requests for waiver program eligibility.

IV. Definitions

A. **Dependent/Immediate Family Members** – As defined by the Internal Revenue Service (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.
B. **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.
C. **Functional Assessment** – The current KDADS approved tool used by a state-contracted assessor to assess a person's functional eligibility.
D. **Functional Eligibility** - The process whereby a member is determined to meet the level of care need for an institutional setting to access a Medicaid-funded HCBS waiver program as determined by a state-contracted assessor.
E. **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.
F. **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.

Updated 11/21

G. **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.
H. **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.

APPENDIX

Codes

Updated 05/19

The following procedure codes represent an all-inclusive list of HCBS TA waiver program services billable to KMAP for HCBS TA members. Procedures not listed here are not reimbursable.

T1001	**HEALTH MAINTENANCE MONITORING – RN/LPN** One unit equals one visit.
S5165	**HOME MODIFICATION** Per service.
T1002	**INTERMITTENT INTENSIVE MEDICAL CARE – RN** One unit for up to 15 minutes, not to exceed 16 units per day.
T1004	**PERSONAL CARE SERVICES (AGENCY-DIRECTED)** One unit for up to 15 minutes.
T1019	**PERSONAL CARE SERVICES (SELF-DIRECTED)** One unit for up to 15 minutes.
T1005	**MEDICAL RESPITE – RN/LPN** One unit for up to 15 minutes.
T1000	**SPECIALIZED MEDICAL CARE – RN/LPN** One unit for up to 15 minutes.