KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

General Benefits

PART I
GENERAL BENEFITS
KANSAS MEDICAL ASSISTANCE PROGRAM

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General Benefits

2000. Medicaid Eligibility Updated 08/08

Introduction to Eligibility

Eligibility in Kansas is ~~determined at the local county SRS offices~~ based on uniform statewide criteria. Eligibility information for each beneficiary is forwarded from the eligibility staff located in the regional offices and the Healthwave clearinghouse ~~county~~ to the SRS Division of Information Resources where it is incorporated into a central eligibility file. The State then sends an eligibility file to EDS. Each claim submitted by providers for payment processing is verified for consumer eligibility. Unless an individual is identified as eligible for the date of service submitted, payment cannot be made for a Medicaid or MediKan claim.

~~Computer-Generated Medicaid Identification~~ Plastic Medical Card

Every individual beneficiary for medical assistance under the Kansas Medical Assistance Program (KMAP) receives a ~~monthly~~ plastic State of Kansas Medical Card. The plastic medical card contains three key pieces of information: member name, member ID and member date of birth. The plastic medical card will only be reissued if there is a change in member name or member ID. If the beneficiary becomes eligible after more than 12 months of ineligibility, a new plastic medical card will be issued. Cards can be replaced if requested by the beneficiary in certain situations. ~~An individual who does not receive a card for the upcoming month is not eligible for medical assistance. It is important for providers to check the medical ID card each time a service is provided to be sure the service date falls within the covered period and to verify codes and programs which may affect program benefits.~~

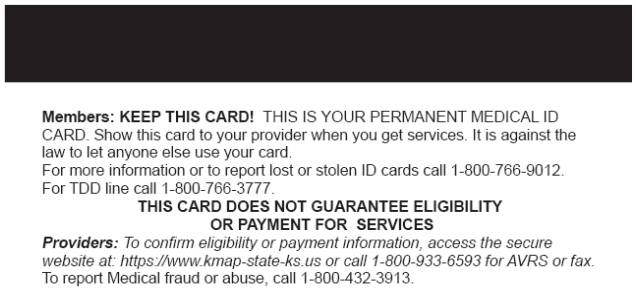
Eligibility information does not appear on the plastic medical card. Providers are responsible for verifying eligibility and coverage before providing services. Possession of a card does not guarantee eligibility. Changes in eligibility, assignment, spenddown amounts, level of care, copayment amount,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

- **Magnetic Swipe Technology**
  - The plastic medical card uses the same swipe technology used for credit cards.
  - This technology allows providers to use a card reader and a service provider to automatically access real-time beneficiary eligibility information through MMIS.
- **AVRS (Automated Voice Response System)**
  - This resource automatically provides the beneficiary's eligibility over the telephone.
  - It is available 24 hours a day, seven days a week.
  - The entire call takes less than one minute.
- **AVRS Faxback**
  - This resource sends a fax to the provider's fax machine with the beneficiary's eligibility listed.
  - The fax service is available 24 hours a day, seven days a week.
  - The entire process takes about 30 seconds. The fax begins within seconds of ending the call.

2000. Medicaid Eligibility Updated 08/08

- **Secure KMAP Web Site**
  - The secure KMAP Web site allows staff with authorization to conduct real-time eligibility verifications.
  - Staff simply enters the beneficiary's ID and the date of service.
  - This service is available 24 hours a day, seven days a week.
- **Customer Service**
  - Eligibility can be verified by calling KMAP Customer Service at 1-800-933-6593 and speaking with an agent.
  - This service is available between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday.

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



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

2000. Updated 11/03

An example of a medical card is in the forms section at the end of this manual

Explanation of ID Card Fields:

Item 1: **CO. #** - Three digit county code. DO NOT LIST ON CLAIMS.

Item 2: **CARD EXPIRES** - Last date of coverage for this card.

Item 3: **PERSON COVERED** - Last name, first name, middle initial of the individual consumer.

Item 4: **PROGRAM** - Disregard program number. DO NOT LIST ON CLAIMS.

Item 5: **ID NUMBER** - Eleven digit ID number of individual consumer.

Item 6: **START DATE** - First date of coverage for this card.

Item 7: **BIRTHDATE/SEX** - Consumer's date of birth and sex.

Item 8: **CASE NAME** - Name of casehead. DO NOT LIST ON CLAIMS.

Item 9: **PROGRAM IDENTIFICATION** - Will **only** print codes applicable to coverage for this consumer.

(a) The OFFICE VISITS (OV) field identifies the number of times the consumer has been to the doctor's office in the current year.

(b) The LST KBH SCR field indicates the last date a medical KAN Be Healthy screen was performed.

*The NXT KBH SCR reflects the next due date for a screen according to the Medicaid periodicity schedule. A screening may be performed before this date if it is more convenient for the provider and consumer.

If a consumer has never had a medical screen the letters ASAP (as soon as possible) will be indicated.

(c) MCD = Medicaid; MKN = MediKan; QMB (RED Card) = Qualified Medicare Beneficiary Only; Q&M (GREEN Card) = QMB and Medicaid eligible; ACHS, ACHD, and ACHN = Adult Care Home Resident (the fourth letter indicated (S, D, or N) is significant to ACH providers only); HCBS = Home and Community Based Services (HCBS) consumer. For beneficiaries in an HCBS waiver program, the waiver program will be indicated as follows:

HCDD = Mental Retardation/Developmental Disabilities
HCFE = Frail Elderly
HCHI = Head Injured
HCPD = Physically Disabled
HCSE = Children With Severe Emotional Disturbance
HCTA = Technology Assisted

When a consumer is **only** eligible for inpatient tuberculosis treatment, 'TB ONLY' is indicated in this field. The 'TB' designation allows the holder to receive **only inpatient care** related to the diagnosis of TB.

2000. Updated 08/08

Filing Proof of Eligibility

When a claim is denied "beneficiary ineligible for date(s) of service" on the remittance advice (RA) and you have proof of KMAP eligibility, attach eligibility documentation, along with an explanation of the problem, to the Eligibility Assistance Form ~~(refer to form example shown on the following page)~~. Any of the following documentation is acceptable for proof of KMAP eligibility:

- A verification number from the Beneficiary Eligibility Verification System (BEVS) accessed from the Automated Voice Response System (AVRS) or point of sale (POS) inquiry
- ~~A copy of the beneficiary's medical identification card~~
- A print out from POS BEVS

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

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

ASSISTANCE OBTAINING MEDICAID ID NUMBER

Request beneficiary eligibility information through AVRS, using the eligibility instructions outlined in Section 1210 or POS BEVS, using the eligibility instructions provided in the accompanying manual.

(d) 1) If the consumer is in an Adult Care Home, "ACH" prints with a figure indicating the number of therapeutic home visits used in the current calendar year.

(e) The EYE EXAM indicator notes if an eye exam has been performed in the past four years (Y/N).

(f) The EYEGLASS field indicates the last date that eyeglasses were dispensed for the consumer. "P" indicates partial dispensing of lens or frames. Call AVR for details.

(g) The message "DATA CONTAINED ON THIS CARD MAY HAVE CHANGED AFTER PRINTING" will be printed on each card. This notation relates only to items 9a through g. Basic eligibility start and stop dates will not change during the month.

Item 10: **PRIMARY PROVIDER** – Name of primary care case manager, Health Maintenance Organization (HMO), Children and Family Services (CFS) contractor, and/or Hospice provider. For beneficiaries assigned to a Children and Family Services (CFS) contractor, the CFS contractor name followed by a two-digit program name (**AD** = Adoption, **FC** = Foster Care, and **FP** = Family Preservation) will display. **Field will be blank if not applicable.** Refer to Section 2200 HealthConnect Kansas Program, Section 2210 HealthWave XIX Kansas Program, Section 2800 Hospice, and/or Section 2900 Children and Family Services Contractors, for more information.

Item 11: **LOCK-IN PROVIDER** – Name of Lock In provider. For beneficiaries assigned to a primary care case manager or HMO **and** a Children and Family Services (CFS) contractor, the CFS contractor name followed by a two-digit program name (**AD** = Adoption, **FC** = Foster Care, and **FP** = Family Preservation) will display. **Field will be blank if not applicable.** (Refer to Section 2400 Lock In and/or Section 2900 Children and Family Services Contractors, for more information.

Item 12: **LOCK-IN PROVIDER NUMBER** – Kansas Medical Assistance Program provider number of Lock In Provider – **Field will be blank if not applicable.** If more than one type of Lock In provider is applicable, that information will be printed on the card.

Item 13: **TPL/HMO** – Any other insurance information on file at the time the card is printed will appear here. Name, address, policy number, and group number will print if available, including HMO's and Medicare coverage type. A coverage indicator will be printed for each policy on file as listed in Section 3100 of this manual. **Other insurance resources must be billed prior to billing the Kansas Medical Assistance Program.**

IMPORTANT: The ID card is not valid unless the beneficiary has signed the back of it, authorizing a release of medical information. Check the card for a valid signature before providing services.

2010. MEDIKAN Updated 08/08

Introduction to the MediKan Program

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

MediKan Benefits and Limitations

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

Identifying MediKan Beneficiaries

See Section 2000 for complete information on plastic medical cards and eligibility verification.

~~If the beneficiary is MediKan, the medical paper ID card will read "**MKN**" in item #9(c).~~

Noncovered MediKan Program Areas

- Adult day treatment
- Behavior management
- Chiropractic
- Dental
- HCBS services
- Intermediate/day treatment alcohol and drug addiction treatment facility services
- Nonemergency and nonambulance medical transportation
- Podiatry
- Vision services

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

Prescription Drug Coverage

Pharmaceutical benefits for MediKan beneficiaries are limited to prescription drugs that have been accepted for inclusion on the MediKan specific formulary.

2020. KAN BE HEALTHY Updated 08/08

INTRODUCTION TO KAN BE HEALTHY

KAN Be Healthy (**KBH**) is a Title XIX program, which provides preventive health care and immediate remedial care for the prevention, correction, or early control of abnormal conditions. It is available to beneficiary's who are age 20 years or under. This program is referred to as Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) at the federal level. KBH is not a MediKan program. Noncovered Kansas Medical Assistance Program (KMAP) services may be covered for KBH beneficiaries when Kansas Health Policy Authority (KHPA) determines the services as medically necessary. Medical necessity must be presented, and prior authorization (PA) must be obtained. Program limitations on covered procedures may be exceeded when prior authorized (refer to Section 4300).

KBH Participation/Eligibility

Beneficiaries, who are 20 years of age and under, are considered KBH enrolled participants and are eligible for the KBH program until turning 21 years of age.

KBH PERIODICITY SCHEDULE

Screening frequencies are based on the 2007 American Academy of Pediatrics "Recommendations for Preventive Pediatric Health Care" as published on the AAP Web site, as of November 5, 2007. The first screen may be performed at any age under 21 and repeated according to ideal timeframes listed in the KBH Screening Frequencies table below. When the ideal schedule is not possible to follow, please note that KBH medical screens may be completed at any time.

Note: Every KBH visit must have all components completed and documented.

Medical Screenings

(M) Medical screens follow the KBH minimum documentation requirements which include the hearing, vision, and dental screening.

Dental Screenings

(D) Dental screens are a required component of each KBH visit based on both the Kansas State and AAPD/ADA/AAP Periodicity Schedule.

Vision Screenings

(V) Vision screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School vision screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Vision Screening Guidelines.

2020. Updated 08/08

Hearing Screenings
(H) Hearing screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School hearing screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Hearing Screening Guidelines and Resource Manual.

KBH Screening Frequencies
Age with Type of Screens Due

Birth: M, V, H	Two to five days after birth: M, V, H	One month: M, V, H
Two months: M, V, H	Four months: M, V, H	Six months: M, V, H
Nine months: M, V, H, D	12 months: M, V, H, D	15 months: M, V, H, D
18 months: M, V, H, D	24 months: M, V, H, D	30 months: M, V, H, D
Yearly three - 20 years: M, V, H, D		

KBH SCREENING PROVIDERS

KBH Screening Providers
The following KMAP providers may complete KBH screens:

- Physicians
- Dentists (KBH dental screens)
- Physician Assistants (PAs)
- Advanced Registered Nurse Practitioners (ARNPs)
- Registered Nurses (RNs) that have been trained to complete KBH screenings. (Registered nurses cannot independently enroll for reimbursement as KMAP providers.)

2020. Updated 08/08

Reimbursement for KBH Screens
KBH screens will be reimbursed when performed by any of the above and billed by:

- Advanced Registered Nurse Practitioner
- Attendant Care for Independent Living
- Community Mental Health Center
- Federally Qualified Health Center
- Head Start facility
- Home Health Agency
- Indian Health Center
- Local Education Agency
- Local Health Department
- Physician
- Physician Assistant
- Rural Health Clinic

KBH SCREENING GUIDE:

KMAP, KBH screening providers have multiple options to bill for, be reimbursed for, and ensure that the beneficiary's KBH screens update appropriately. The billing options include:

1) An evaluation and management (**E/M**) preventative medicine Current Procedural Terminology (**CPT**) code (99381-99385 or 99391-99395) with modifier 32;
2) An E/M office visit CPT code (99201-99205 or 99211-99215) with modifier 32 and wellness diagnosis code (V20-V20.2 and/or V70.0 and/or V70.3-70.9);
3) An E/M preventative medicine CPT code without modifier 32;
4) An E/M office visit CPT code without modifier 32 and with wellness diagnosis code;
5) Finally, there are additional CPT codes that will update one KBH screen only; additional CPT codes update one medical, dental, vision, or hearing KBH screen.

The following guide will initially review the above first and second KBH screen billing options and the minimum documentation requirements. Modifier 32 signifies a mandated service has been completed. KMAP utilizes modifier 32 for its federally mandated EPSDT program, which is also known as KAN Be Healthy. Modifier 32 not only identifies that the KMAP provider has met minimum documentation requirements, but also that a set $70.00 reimbursement should be paid. Please see below and review additional outlined directives when billing modifier 32 and an E/M preventative medicine or office visit CPT code.

2020. Updated 08/08

E/M PROCEDURE CODES WITH MODIFIER '32'

Modifier 32 Directives:

- Modifier 32 indicates that all twelve of the KBH screening components are minimally documented.
- Modifier 32 may only be billed with an E/M preventative medicine (99381-99385 or 99391-99395) or office visit (99201-99205 or 99211-99215) CPT code.
- Billing an E/M office visit CPT code and a wellness diagnosis code (V20-V20.2 and/or V70.0 and/or V70.3-70.9) is encouraged when the intent of the scheduled visit was a KBH screen and an abnormality was diagnosed.
- E/M office visit CPT codes must be billed in conjunction with at least one wellness diagnosis code (V20-V20.2 and/or V70.0 and/or V70.3-70.9).
- When an office visit CPT code is billed with modifier 32 without a wellness diagnosis, the service will be **denied** and the KBH screens will not update.
- Screening providers are reimbursed $70.00.
- ARNP/PA providers will be reimbursed $70.00 when an E/M preventative medicine or office visit CPT code is billed with modifier 32. All other CPT codes billed by an ARNP/PA provider will continue to be paid at 75% of the maximum reimbursement amount (RHC & FQHC providers continue to receive their usual and customary encounter reimbursement rate.)
- Blood lead level collection may not be referred to another provider. This is a requirement of participating KBH providers.
- Immunization administration, laboratory, and blood lead level analysis may be referred to another provider if the screening agent is unable to provide. Follow referral requirements as outlined in the Referring KBH Screening Components section.
- No other KBH screening component, other E/M CPT preventative medicine and/or office visit code without modifier 32 may be billed separately, other than immunization administration and laboratory (excluding blood level poisoning testing) components.
- If a KBH screening component, other E/M preventative medicine, and/or office visit CPT code without modifier 32 is billed on the same date of service as an E/M preventative medicine or office visit CPT code and modifier 32, only the first detail (first line or first claim processed) will be paid, and all following details will be denied.

2020. Updated 08/08

Billing E/M **Preventative Medicine or Office Visit CPT Codes**	Modifier 32	**Other Component Parts or CPT visit Billed**	**Diagnosis Code**	**KBH Screens Updated**	**Claim Status***	**Payment Amount**
E/M preventative medicine CPT code	**WITH**	No	Any	All Four	Paid	$70.00
E/M preventative medicine CPT code	**WITH**	Yes	Any	Depending upon initial detail processed.	Initial detail paid.	Depending upon initial detail processed.
E/M office visit CPT code	**WITH**	No	Wellness	All Four	Paid	$70.00
E/M office visit CPT code	**WITH**	No	Not Wellness	None	Denied	$0.00
E/M office visit CPT code	**WITH**	Yes	Wellness	Depending upon initial detail processed.	Initial detail paid.	Depending upon initial detail processed.
E/M preventative medicine CPT code	**WITHOUT**	Yes	Any	All Four	Paid	Usual Rate (ARNP/PA @ 75%)
E/M office visit CPT code	**WITHOUT**	Yes	Wellness	All Four	Paid	Usual Rate (ARNP/PA @ 75%)
E/M office visit CPT code	**WITHOUT**	Yes	Not Wellness	None	Paid	Usual Rate (ARNP/PA @ 75%)

*****Please note, that the above claim status is an example when KMAP benefits and limitations are met.

2020. Updated 08/08

KBH Screening Components: Minimum Documentation

A KBH screen must consist of at the minimum:

1. Medical History
2. Physical Growth
3. Body Systems
4. Developmental/Emotional
5. Nutrition
6. Health Education & Anticipatory Guidance
7. Blood Lead
8. Laboratory
9. Immunizations
10. Hearing Screening
11. Vision Screening
12. Dental Screening

- Documentation must be maintained in the beneficiary's permanent medical record.
- Blood lead level collection may not be referred to another provider. This is a requirement of participating KBH providers.
- Immunization administration, laboratory, and blood lead level analysis may be referred to another provider if the screening agent is unable to provide. Follow referral requirements as outlined in the Referring KBH Screening Components section.
- When it is not possible to complete a screening component(s), document the reason, e.g. due to lack of patient cooperation, diagnosed sickness, or physical/mental handicap. Scheduling a follow-up visit is encouraged to complete the screening components. Components must not be left blank or undocumented. NA (not appropriate) and generalized documentation, such as Physical WNL, is not acceptable documentation.
- Documentation by exception is not accepted.

The twelve KBH screening components must follow the minimum documentation requirements listed when billing an E/M preventative medicine or office visit CPT code with modifier 32. Providers who elect to bill utilizing multiple CPT codes rather than utilizing the 32 modifier must also satisfy the documentation requirements found within the CPT manual.

1. Medical History

Obtain the beneficiary's family and self-history information at the time of the initial screen and update as needed and maintain in the medical record.

- Family history, which includes parent, grandparent, and sibling, must include: allergies (food and drug), birth defects, blood disorders, cancer, diabetes, drug or ETOH abuse, heart disease/stroke, high blood pressure, kidney/liver disease, lung disease, mental illness, obesity, epilepsy/seizures, scoliosis/arthritis, speech, visual, or hearing problems, ulcers/colitis, urinary/bowel, and any other significant information
- Self-history must include the minimum: allergies (food and drug), birth history (if known), serious illness/accidents, operations, and medications as well as any other significant information

2020. Updated 08/08

2. Physical Growth

- Record a head circumference for beneficiaries less than two years of age at each screen.
- Maintain a growth chart for the recumbent length or standing height, weight, and head circumference and update at each screen. After age two, include a calculated body mass index (BMI) percentile at each screen. Beneficiaries with a greater than or equal to 85% ranking on the Center for Disease Control body mass index-for-age percentiles chart must receive recommendations regarding appropriate nutrition and physical activity from the KBH screener. This must be reflected in the documentation at the time of the KBH screen.
- Blood pressure is required for beneficiaries three to 20 years of age.
- Full set of vital signs, as indicated.

3. Body Systems

a. Perform a comprehensive, unclothed physical screen including height and weight at each screen.

b. Complete and document a screen of the gastrointestinal, central nervous system, musculoskeletal, integumentary, cardiovasular/pulmonary, and gential/urinary systems at each KBH screening visit.

Cardiovascular/Pulmonary

- Documentation must minimally include: heart rate (pulse), heart tones, and lung sounds.
- Document blood pressure on beneficiaries three years of age and older at each screen.

Genital/Urinary

Documentation observations must minimally include:

- Tanner stage of development
- History of or current enuresis
- Evaluation of excessive menstrual bleeding

4. Developmental/Emotional

Every child is required to have developmental surveillance at every KBH screen. Provision of developmental surveillance at every KBH screen allows for consistent surveillance and a strategy to measure, document and circumvent serious developmental challenges.

- Beneficiaries under six years of age:
  A standardized developmental screening tool(s) must be completed, interpreted, and the report must be documented at each KBH screen and be maintained in the beneficiary's permanent medical report. The American Academy of Pediatrics (AAP) identified in their 2006 policy statement that the Denver Developmental Screening Test II (DDST II) has a low to moderate sensitivity and specificity rating.

2020. Updated 08/08

Examples of more sensitive and specific screening tools that may be used are:

1. Ages and Stages Questionnaires (ASQ) – also available in Spanish, French and Korean for use with children four months to five years of age.
2. Parent's Evaluations of Developmental Status (PEDS) – also available in Spanish and Vietnamese for use with children birth to eight years of age.
3. Modified Checklist for Autism in Toddlers (MCHAT) – also available in Spanish, Turkish, Chinese and Japanese for use with children 15 to 30 months of age.
   a. If a child is being seen regularly and developmental surveillance is provided at every KBH visit, use the MCHAT tool during the above time frames to assess for speech language developmental delays and/or autism spectrum disorders.
   b. If, however, the child is only being seen sporadically, both a general developmental tool and the MCHAT should be administered at the above time frames to ensure appropriate developmental milestones are being met and to rule out potential speech language developmental delays and/or autism spectrum disorders.

- Beneficiaries age six years and up must have either one or both of the following:
  1. Document general developmental and emotional observations, which must minimally include information regarding: exercise, sleep habits, emotional, peer interaction, school (grade, average grades, days missed, vocational, and special education/needs), and any other significant information as needed.
  2. A standardized developmental screening tool(s) with interpretation and report. An example of a screening tool for six years of age and older is the Pediatric Symptom Checklist (PSC). The completed report and tool must be maintained in the beneficiary's permanent medical record, as well as any referrals for services.

5. Nutrition

Complete a nutritional screen, and document the nutritional intake and status at each screen, which could include: WIC participation, breast feedings/type of formula (amount and/or how often), diet history, twenty-four hour recall, food allergies, anemia, supplements, vitamins, and potential for being overweight. Documentation such as "eats good" or "picky eater" is not appropriate.

Note: Recent studies support both the physical and emotional benefits of breastfeeding for a minimum of one year. The initiation and maintenance of breastfeeding present challenges to many mothers regardless of age, race, economic status, or family size. However, babies most in need of the benefits that breastfeeding provides are frequently from the lowest socio-economic group. Breast milk is economical and readily available on demand. If mother and child are separated for periods of time due to job responsibilities, breast milk can be pumped and stored. Breast pumps are available with a prescription from a physician and are available through a durable medical equipment (DME) provider. Refer to the *DME Provider Manual* for additional details. Additionally, La Leche Leagues and many community hospitals provide free lactation and peer support.

2020. Updated 08/08

6. Health Education and Anticipatory Guidance

This component must include education regarding the child's development, benefits of healthy lifestyles, and accident and disease prevention. Provide diet instruction as necessary. Provide or refer family planning services as indicated. Education and discussion in this area must be age-based. Documentation must minimally include topics discussed. If any referrals result from this interaction, these are also to be documented.

7. Blood Lead

All children are considered at high risk and must be screened for lead poisoning. Centers for Medicare and Medicaid Services (CMS) requires that all children receive a screening blood lead test at both 12 and 24 months of age. Children between the ages of 36 and 72 months of age, who have not received a blood lead test previously, must receive a screening blood test.

A blood lead test result equal to or greater than 10ug/dl obtained by capillary specimen (finger stick) must be confirmed by collecting a venous blood sample.

Documentation supporting blood lead poisoning, risk-factor, verbal screening and testing, including results, must be maintained in the beneficiary's permanent file. Verbal screening utilizing the KBH Mandatory Blood Lead Screening Questionnaire is mandatory at each KBH screen between the ages of six and 72 months. This form can be found in the forms section of the *General Benefits Provider Manual* or on the KMAP Web site at: https://www.kmap-state-ks.us/.

Contact the Kansas Healthy Homes and Lead Hazard Prevention Program (KS HHLHPP) – Kansas Department of Health and Environment (KDHE) regarding blood lead poisoning, additional screening information and/or testing information at: 1000 SW Jackson Street, Suite 330, Topeka, Kansas 66612-1274, by phone at 866-865-3233, or by fax at 785-296-5594. Their email address is lead@kdhe.state.ks or http://www.unleadedks.com/.

Testing supplies may be ordered through the KDHE laboratory at 785-296-1623.

The Kansas Division of Health and Environmental Laboratories (DHEL) blood lead sample methodologies include: collection of a venous sample, collection of a capillary sample using a capillary tube (microtainer or vacutainer), collection of a capillary sample placing blood drops on filter paper, and collection of a capillary sample and using the lead care analyzer. Supplies must be ordered on a Requisition for Laboratory Specimen Kits form available on the Kansas Healthy Homes and ~~Childhood~~ Lead Hazard ~~Poisoning~~ Prevention Program (KS HHLHPP) ~~(KCLPPP)~~ Web site at http://www.unleadedks.com.

Additionally, the requisition is in the Forms section at the end of this manual. Copy and use to insure sufficient supplies are available to perform mandatory blood lead testing.

2020. **Updated 08/08**

The six blood lead poisoning verbal screening questions are:
Does your child:

1. Live in or visit a house or apartment built before 1960? (This could include a day care center, preschool, or the home of a baby-sitter or relative.)
2. Live in or regularly visit a house or apartment built before 1960 with previous, ongoing, or planned renovation or remodeling?
3. Have a family member with an elevated blood lead level?
4. Interact with an adult whose job or hobby involves exposure to lead? (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and making pottery)
5. Live near a lead smelter, battery plant, or other lead industry? (Ammunition/explosives, auto repair/auto body, cable/wire striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten metal [foundry work])
6. Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?

One positive response to the above questions requires a blood lead level (BLL) test. Ask any additional questions that may be specific to situations that exist in a particular community.

Results received from verbal blood lead screenings must be recorded on the KBH Mandatory Blood Lead Screening Questionnaire located in the Forms section of this manual and on the KMAP Web site under Publications, Forms. This form must be maintained in the beneficiary's medical record.

8. Laboratory

Complete blood count with automated differential (85025):

- Infants, once between the ages of nine and 12 months, perform and document the initial screen results
- Adolescent males
    - Routinely at age 15, perform and document the screen results
    - Annually thereafter if any of the following apply:
        - A student athlete
        - A vegetarian
- Adolescent females
    - Routinely at the age of menarche, perform and document the screen results
    - Annually thereafter if any of the following apply:
        - History of heavy menstrual flow (soaking more than three pads per day)
        - A student athlete
        - A vegetarian

2020. Updated 08/08

9. Immunizations

Immunizations must be reviewed at each screen and brought up to date as necessary, according to age and health history. A complete record must be maintained in the beneficiary's medical record. (See the *Professional Provider Manual*, Appendix I, for immunization administration and billing information.)

Refer to the most current immunization schedule recommendations from the National Center for Immunization and Respiratory Disease (NCIRD) at http://www.cdc.gov.

If a Vaccines for Children (VFC) provider, use the VFC stock for Medicaid and S-CHIP beneficiaries. Please contact Kansas Department of Health and Environment (KDHE) at 785-296-1500 or http://www.kdheks.gov.

10. Hearing Screening

Documentation must include either a paper hearing screen or a qualified hearing screen, identified as the following:

- Paper Screen Option
  The following paper hearing screen forms must be maintained in the beneficiary's permanent medical record. Each form is available on the KMAP Web site at https://www.kmap-state-ks.us under the KAN Be Healthy link. Documentation must include interpretation and/or results.
  - Birth to four years of age, both forms below are required:
    - Risk Indicators for Hearing Loss Checklist
    - Hearing Developmental Scales
  - Over four years of age, the Hearing Health History form is required.

In the event the KBH screener determines that the beneficiary has not passed the paper hearing screen, a referral for further evaluation is required. The Kansas Chapter of the AAP recommends the following testing procedures for further evaluation.

- Birth to two years of age, an Auditory Brainstem Response (ABR) or Otoacoustic Emissions (OAE) is recommended.
- Two to four years of age, play audiometry is recommended.
- Over four years of age, conventional audiometric screening is recommended.

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- Hearing Screening Procedure Option
  The following procedures qualify as an allowed KBH hearing screen:
  - Audiometric sweep screen for beneficiaries age four years of age and up
  - Screening test, pure tone, and air only
  - Pure tone audiometry
  - Pure tone audometry – air and bone
  - Speech audiometry – threshold only
  - Speech audiometry with speech recognition
  - Comprehensive audiometry threshold evaluation
  - Conditioning play audiometry
  - Evoked otoacoustic emissions: limited (single stimulus level, either transient or distortion products)

  Note: Documentation must include testing parameters, interpretation and results.

11. Vision Screening

Birth to three years of age:

1. Ocular history
   - Parental observation including the following questions:
     - Does your child seem to see well?
     - Does your child hold objects close to his or her face when trying to focus?
     - Do your child's eyes appear unusual?
     - Do your child's eyelids droop or does one eyelid tend to close?
     - Has one or both of your child's eyes ever been injured?
   - Review family history
2. Eye tracking – ability to fix and follow objects
3. External inspection of the eyes and lids – penlight evaluation of the lids, conjunctiva, sclera, cornea and iris
4. Ocular motility assessment – testing for strabismus with the cross cover test
5. Pupil examination – equal, round and reactive to light
6. Corneal light reflex

Three years of age and older:

1. Ocular history
   - Parental observation including the following questions:
     - Does your child seem to see well?
     - Does your child hold objects close to his or her face when trying to focus?
     - Do your child's eyes appear unusual?
     - Do your child's eyelids droop or does one eyelid tend to close?
     - Has one or both of your child's eyes ever been injured?
   - Review family history

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2. Vision assessment
    a. Children three to four years of age – LH symbols and Allen cards
        - If three-year-old child is unable to do in two attempts, repeat in four to six months.
        - If four-year-old child is unable to do in two attempts, repeat in one month.
        - If either remains unable, refer to appropriate specialist.
    b. Children four years of age and older – wall charts including Snellen letters or numbers or tumbling E and near acuity cards
    c. Vision testing machines

    Note: If using this option, the results of the vision test must be documented, not just the fact that the machine was used to test.
3. External inspection of the eyes and lids – penlight evaluation of the lids, conjunctiva, sclera, cornea and iris
4. Ocular motility assessment – testing for strabismus with the cross cover test
5. Pupil examination – equal, round and reactive to light
6. Red reflex examination – view pupil from 12-18 inches from the eye in a darkened room (Bruckner Test)
7. Eye tracking – ability to fix and follow
8. Attempt at ophthalmoscopy

12. Dental Screening

Document must include minimal documentation of oral and dental observations while completing a KBH screen. At each KBH screen, a determination must be made whether or not the child has been examined by a dentist. If no dentist has been involved in the child's care by age one, a dental referral must be made by the KBH screener and documented in the medical record. The State of Kansas strongly recommends every child have a dental home with annual dental exams. Additionally, two periodic dental visits are allowed per year.

Note: A screen of the oral/dental cavity during a KBH medical screen does not constitute a comprehensive dental exam.

Additionally, physicians (general practitioners, pediatricians and family practice physicians), nurse practitioners and physician assistants may provide topical application of fluoride (prophylaxis not included) for children. This service is limited to three applications per beneficiary per calendar year. Claims may be submitted using procedure code D1203 on the HCFA-1500 claim form.

Note: This policy does not apply to local health departments or federally qualified health centers.

2020. Updated 08/08

KAN BE HEALTHY PROVIDER RESPONSIBILITIES

E/M PROCEDURE CODES: UPDATE ALL FOUR KBH SCREENS WITHOUT MODIFIER 32 (bill customary charges)

KBH screens will continue to update when an E/M preventative medicine or office visit CPT code, without modifier 32, is billed. The following guidelines must be followed in order to update the KBH screens.

- Documentation must support the procedure code claimed. KMAP encourages reviewing and ensuring documentation meets American Medical Association procedure code guidelines found within the latest edition of Current Procedural Terminology (CPT).
- E/M office visit CPT codes must be billed with a wellness diagnosis (V20-V20.2 and/or V70.0 and/or V70.3-70.9) in order to update the KBH screens.
- In order to maximize reimbursement, additional KBH screening components may be billed separately only when billing an E/M preventative medicine or office visit CPT code **without** modifier 32. Additional component examples may include: vision screen (99173), developmental screen (96110 or 96111), and hearing screen (example 92552).
- Refer to KMAP manuals and review benefits and limitations.

E/M PREVENTATIVE MEDICINE PROCEDURE CODES (without modifier 32)

99381	Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year).
99382	early childhood (age 1 through 4 years)
99383	late childhood (age 5 through 11 years)
99384	adolescent (age 12 through 17 years)
99385	18-39 years
99391	Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
99392	early childhood (age 1 through 4 years)
99393	late childhood (age 5 through 11 years)
99394	adolescent (age 12 through 17 years)
99395	18-39 years

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E/M OFFICE VISIT PROCEDURE CODES (WITHOUT MODIFIER 32):
E/M office visit procedure codes must be billed with a wellness diagnosis (V20-V20.2 and/or V70.0 and/or V70.3-70.9) in order to update the KBH screens.

New Patient - Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

99201 A problem focused history; a problem focused examination; and, straightforward medical decision-making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202 An expanded problem focused history; an expanded problem focused examination; and, straightforward medical decision-making. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203 A detailed history; a detailed examination; and, medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 A comprehensive history; a comprehensive examination; and, medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205 A comprehensive history; a comprehensive examination; and, medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established Patient - The following office or other outpatient visit procedure codes for the evaluation and management of an established patient require at least two of the three key components listed. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

99211 Office or other outpatient visits for the evaluation and management of an established a patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 A problem focused history; a problem focused examination; and, straightforward medial decision-making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213 An expanded problem focused history; an expanded problem focused examination; and, medical decision making of low complexity. Usually, the presenting problem(s) are low to moderate. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

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99214 A detailed history; a detailed examination; and, medical decision making of moderate complexity. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 A comprehensive history; a comprehensive examination; and, a medical decision making of high complexity. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

When the primary diagnosis is pregnancy with procedure codes 99056, 99058, 99281, 992001-99205, and 99211-99215 the KBH medical screen will update once every 270 days (nine months).

PROCEDURE CODES THAT UPDATE THE KBH MEDICAL SCREEN ONLY
(Bill customary charges)

59400 Total obstetric care (all-inclusive, "Global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care

59409 Vaginal delivery only (with or without episiotomy and/or forceps)

59410 including postpartum care

59425 Antepartum care only; 4-6 visits

59426 Antepartum care only; 7 or more visits

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59514 Cesarean delivery only

59515 including postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)

59614 including postpartum care

59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

59622 including postpartum care

99221 Initial Hospital Care, per day.

99222 Initial Hospital Care, per day.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

99291 Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour.

99295 Initial Neonatal Intensive Care, per day.

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99431 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records.

99432 Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s).

99435 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

PROCEDURE CODES THAT UPDATE THE KBH HEARING SCREENS ONLY
(Bill customary charges)

92551 Screening test, pure tone, and air only.

92552 Pure tone audiometry.

92553 Pure tone audiometry - air and bone.

92555 Speech audiometry - threshold only.

92556 Speech audiometry with speech recognition.

92557 Comprehensive audiometry threshold evaluation.

~~**92567** Tympanometry.~~

92582 Conditioning play audiometry.

92587 Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products).

PROCEDURE CODES THAT UPDATE THE KBH VISION SCREENS ONLY
(Bill customary charges)

99173 Screening test of visual acuity, quantitative, bilateral. (The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity [e.g. Snellen chart].) Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service of an E/M service of the eye, it is a diagnostic examination and not a screening test.

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient.

92004 Comprehensive, new patient, one or more visits.

92012 Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient.

92014 Comprehensive established patient, one or more visits.

PROCEDURE CODES THAT UPDATE THE KBH DENTAL SCREENS ONLY
(Bill customary charges)

D0120 Periodic oral examination.

D0140 Problem focused oral examination.

D0150 Initial oral examination (new patient limited to first time seen).

D0170 Re-evaluation – limited, problem focused (established patient, not post-op visit).

D9420 Hospital call.

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KBH REFERRAL RESPONSIBILITIES

Referring KBH Screening Components

Newly enrolled beneficiaries may be referred for KBH screens by the local SRS office, an outreach agency, another provider, or the beneficiary may request a screen without being referred. Beneficiaries enrolled in a managed care program must have their KBH screens completed by their primary care case manager. A referral is required if a provider other than the beneficiary's primary care case manager completes the KBH screen. The primary care case manager can choose whether to perform KBH screens or refer them to another KMAP enrolled provider.

When billing an E/M preventative medicine or office visit procedure code with modifier 32 the only two components that may be referred, in order to complete the screen, is immunization administration and laboratory (excluding blood level poisoning testing). Referrals must be documented. Referral documentation must include: the component referred, the provider referred to, and the expected date in which the component will be completed.

Screening providers are encouraged to request the outcome results, and maintain the documentation in the beneficiary's medical record. For example, a beneficiary was referred to a Local Health Department (LHD) to update their immunizations. After administering the immunizations, the LHD is encouraged to provide the updated immunization record to the beneficiary and/or their primary care case manager.

Referrals For Diagnosis Or Treatment

Screening providers should initiate diagnosis and treatment, as their license allows, or refer to another provider(s) who is (are) able to diagnose and provide treatment. Dental and optometric services as well as referrals to a physician who will be able to provide a medical home for continued preventative care, diagnosis, or treatment needs is encouraged.

Refer those potentially eligible to the Services For Children With Special Health Care Needs (Special Health Services - SHS).

KBH Referral Values and How to Claim

KBH referral values are utilized for CMS reporting purposes. Please see the referral values, definitions, and billing instructions below.

When a referral value is present, KBH indicator value (E or B) must also be present. Document one (1) referral value per submitted claim as applicable. Referral values are utilized after a KBH screen has been completed.

- AV: Upon completion of the KBH screen, the screen provider initiated a referral; the beneficiary refused this referral.
- ST: A new referral request has been initiated and the beneficiary accepted the referral.
- S2: An abnormality was observed during the KBH screen; however, the beneficiary is currently under treatment for the observed condition.

Note: Submitting a paper claim or an electronic claim in an 837 Professional format is encouraged.

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CMS-1500 claim form: Referral values are to be claimed in Field 24H. In the shaded area, enter the KMAP provider ID or taxonomy code of the rendering physician. In the nonshaded area, enter the NPI of the rendering physician. The appropriate ID qualifier also needs to be entered in field 24I, 'ZZ' for taxonomy code and '1D' for KMAP provider ID.

837 Professional Claim: Document the referral value within the X12 claim level 2300 loop. Within loop 2300, there are multiple segments. KBH referral values should be billed in the CRC Segment with appropriate data elements as follows:

- CRC01: 'ZZ';
- CRC02 : 'Y'; and,
- CRC03: the appropriate referral value, which is 'AV', 'ST', or 'S2'. HIPAA has labeled this CRC segment with the name of "EPSDT Referral".

Additional Referral Responsibilities

- Ensure the beneficiary (or parent/guardian) is informed the nature and purpose of the referral.
- Provide the beneficiary (or parent/guardian) with the name of an appropriate provider(s).
- Ensure an appointment is made either by your office or by the beneficiary.
- Inform the provider about the condition for which the beneficiary is being referred (and that the beneficiary is a KBH participant), verbally or in writing.
- A report of the service provided must be returned to the primary care case manger.
- Suggest other resources if noncovered services are needed (e.g., local school district for speech evaluation/therapy).

KBH INDICATOR VALUES

KBH and Family Planning indicator values are utilized for reporting purposes. Please see the indicator values, definitions, and billing instructions below.

- KAN Be Healthy (EPSDT) indicator: E
- Family Planning indicator: F
- KAN Be Healthy (EPSDT) and Family Planning indicator: B

CMS-1500 claim form: document the appropriate indicator value in Field 24H.

837 Professional Claim: KBH indicator within the: 2400 Loop, SV111 data element: 'Y'. When the visit contains KBH and a family planning service also document a 'Y' within the 2400 Loop, SV112 data element.

POSITIVE BEHAVIOR SUPPORT SERVICES

Effective January 1, 2002, three Positive Behavior Support (PBS) services were created for KBH beneficiaries. These services are:

PBS Environmental Assessment: An assessment of environmental events, antecedents, and consequences that are associated with or maintain the behaviors of interest, including physiological responses. This service should be billed as 90885 (22). One hour is equal to one unit, and up to 30 hours are covered per year.

2020. Updated 08/08

PBS Treatment: Procedures that include environmental manipulation of one or more of the following: antecedent events, setting events, consequent events, and teaching new skills.
This service should be billed as 90806 (22). One hour is equal to one unit, and up to 60 hours are covered per year.

PBS Person-Centered Planning: The use of person-centered planning approaches that integrate a person's desired quality of life, taking into account barriers to achievement.
This service should be billed as 90882 (22). One hour is equal to one unit, and up to 40 hours are covered per year.

The following conditions apply with respect to these services:

1. The Community Developmental Disabilities Organizations (CDDOs) are the only provider type allowed for reimbursement of these services.

2. Individuals providing PBS services must have, at a minimum, a bachelor's degree and have completed the Kansas Institute for Positive Behavior Support (KIPBS) Training Program.

3. To receive PBS services, the beneficiary must be a KBH beneficiary with a current screen who has obtained prior authorization through the process developed and implemented by KIPBS staff, University of Kansas.
   Note: Typically, the delivery of services will be limited to one billing cycle per beneficiary (the allowable hours of assessment, treatment, and person-centered planning that can be used during a one-year billing cycle).

4. There may be occasions when a case is determined to be so severe that a subsequent year of service is required. If this occurs, an exception may be considered. All exceptions must receive prior authorization using the process developed and implemented by KIPBS staff, University of Kansas.

Note: If the limitation of allowable hours of assessment, treatment, and person-centered planning has not been used during the first year of service, the remaining allotment of billable hours cannot be carried over into the second year as part of any new prior authorized service for an exception. All services approved by the KIPBS prior authorization system as part of an exception will constitute a new service arrangement for a beneficiary with specific limitations and conditions. Once prior authorization is approved for an exception and the one year billing cycle expires, further exceptions will not be considered.

All PBS services must be authorized through the KIPBS prior authorization system. The following conditions apply:

- Only persons who have successfully completed the KIPBS training system and are currently recognized by that system as approved for reimbursement may make application to the KIPBS prior authorization system.
- The KIPBS prior authorization application is available on the Internet at www.kipbs.org. Prior authorization may also be obtained by calling the KIPBS project coordinator at 785-864-4096.
- The KIPBS Prior Authorization team takes action on each application within 48 hours whenever possible.

2020. Updated 08/08

- If the KIPBS Prior Authorization team approves an application, it is faxed to the appropriate fiscal agent contact person for action. KIPBS will also send notification to the PBS facilitator to forward a copy of their Notice of Action on Prior Authorization document to the appropriate parties.
- All approved applications constitute an agreement on the part of the service provider to deliver all PBS services in a comprehensive and integrated fashion. For example, person centered planning, assessment, and intervention should not be separated whenever possible to specialized personnel.
- Service providers maintain internal documentation systems that comply with all necessary regulations and laws pertaining to confidentiality and privacy protection. For all PBS services, documentation for billing should be in quarter of an hour increments. The PBS service provider must maintain a record of the individuals to whom he or she provides services that shows:
  - Name of the individual receiving the service
  - Date the service was provided
  - Name of the provider agency
  - Name of the individual providing the service
  - Location at which the service was provided
  - Type of PBS treatment provided
  - Amount of time it was provided to the nearest quarter hour

OTHER KMAP PROVIDER RESPONSIBILITIES & KBH BILLING GUIDELINES

Report Next KBH Screening Date to Beneficiary

Inform the beneficiary when their next screen is due. Notify the beneficiary when it is time to make an appointment. Children eligible for foster care services require a special written report. The foster parent or SRS worker will provide the form.

File the KBH Screen as Soon as Possible

Providers who perform KBH screens are requested to file their claims as soon as possible. KBH screens are updated under the following conditions: a CMS-1500, electronic claim, or an ADA dental claim form (dental claims only) submitted by an enrolled KMAP provider; a claim with a KBH program recognized procedure code; and, when the claim adjudicates (paid or denied). Adjudicated (paid or denied) claims are utilized to update the beneficiary's screening dates and for required reporting to CMS.

Additional KBH Information

- The initial newborn assessment in the hospital is automatically considered a screen under the following conditions: if the physician bills for his professional services and an appropriate procedure code that will update the KBH screen was billed. The hospital inpatient record is not considered a KBH medical screen.
- The AVR may be used to inquire if or when a beneficiary was screened. (See Section 1200 for more information.)

2020. Updated 08/08

- If a claim for a screen has been processed, the provider may verify the date of the last screening through any of the eligibility verification options. See Section 2000 for complete information on plastic medical cards and eligibility verification ~~the date of the most recent screen is indicated on the Medicaid paper ID card. If there have not been any medical screens billed,~~
  ~~00-00-00 is indicated on the ID card as the last screening date~~.
- For beneficiaries who will be 21 years of age or older when the next medical screen is due, the next screening date will be populated with the day before their date of birth, the day before turning 21 years of age. Beneficiaries are eligible to participate in the KBH program until the day before turning 21 years of age.
- The KBH EPSDT Screening Form provided may be duplicated for your use. This form is not required. However, if this form is properly completed, all KMAP documentation guidelines are met.
- RHC & FQHC KBH trained registered nurses who complete a KBH screen must continue to bill modifier "TD" for all KBH-related services.
- KBH medical, vision, and/or hearing screens may be submitted electronically or on the CMS-1500 claim form. KBH dental screens are submitted on the ADA dental claim form.

STATE INSTITUTION KBH BILLING GUIDELINES

State institutions providing medical screens should:

- Complete the CMS-1500 claim form.
- Use an appropriate KBH screening procedure code.
- Enter the customary charge for the procedure in field 24F of the claim form.
- Submit the claim using the institution's provider number.

Billing KBH screening claims will not result in payment to the state institution. However, the beneficiary's KBH screening dates will update and the claim information will be used for KMAP required reporting purposes.

Note: See the Forms section at the end of this manual for an example of the screening form.

2030. QUALIFIED MEDICARE BENEFICIARIES Updated 08/08

Introduction to QMB

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

Identifying QMB Beneficiaries

See Section 2000 for complete information on plastic medical cards and eligibility verification. ~~Individuals who are eligible only for QMB benefits receive Medicaid paper identification (ID) cards with the word "RED" printed in the lower left corner and are covered only for services that are covered by Medicare. Individuals who are eligible for **both** QMB and Medicaid benefits receive Medicaid paper ID cards with the word "GREEN" in the lower left corner and with "QMB + MCD" coverage (as indicated in field 9c). They are eligible for services covered under Medicare and Medicaid.~~

QMB Benefits and Limitations

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

Beneficiary eligibility benefits fall into two categories:

1. QMB Only
   - ~~Medicaid ID card has the word "Red" in the lower left corner is RED~~.
   - Medicare covered services only. Medicaid considers paying the Medicare coinsurance and deductible, but **the total payment the provider receives will never be more than the Medicaid allowed amount.**
   - QMB's are not eligible for payment of claims for Medicaid services which Medicare does not cover.
2. Medicare (QMB) + Medicaid (Dual Eligible)
   - Medicare covered services. Medicaid considers paying the Medicare coinsurance and deductible, but **the total payment the provider receives will never be more than the Medicaid allowed amount.**
   - Medicaid services. Dual eligibles are eligible for payment of Medicaid services not covered by Medicare. Claims are subject to the normal Medicaid limitations described below. ~~Medicaid ID card has the word "Green" in the lower left corner is GREEN, showing "QMB + MCD".~~

In either case of QMB coverage, if Medicare covered a service, Medicaid program limitations do not apply and are bypassed in the MMIS.

2030. Updated 08/08

Medicaid Program Limitations:

- Prior Authorization requirements
- KAN Be Healthy requirements
- Medical Assessment review

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

For information on state copayment requirements as they apply to QMB, refer to Section 3000.

Billing QMB Claims:

File claims for QMB services in accordance with standard Medicaid billing practices. (Guidelines regarding Medicare assignment remain the same. Refer to Section 3200.) All required claim information must be present, valid and correct or the claim will deny. Refer to Section 7000 in Part II of the provider manual for specific details.

Low Income Medicare Beneficiaries Program:

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

2040. EMERGENCY MEDICAL SERVICES FOR ALIENS: SOBRA Updated 08/08

Introduction to SOBRA - Emergency Medical Services for Aliens

Medical review of emergency services for establishing SOBRA eligibility are performed by the fiscal agent. Providers seeking coverage of emergency services for SOBRA beneficiaries must contact their local SRS office to initiate the eligibility process. Providers must complete Section II of the MS-2156 form (Medical Review of Emergency Services for Purposes of Establishing SOBRA Eligibility) and attach the form to medical records which document the emergent nature of the service(s) being billed for the beneficiary. This information must be mailed to:

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

The records will be reviewed by designated fiscal agent staff and a determination made of the emergent nature of the service(s) based on criteria provided by the State. Once a determination is made, Section III of the MS-2156 form will be completed and forwarded to the local SRS office for completion of the SOBRA eligibility process. Once the local SRS office has completed the eligibility process and the beneficiary is determined SOBRA eligible, the provider may file the claims specific to the service(s) and date(s) authorized. The only exception to this process is for labor and delivery. Covered services provided to the mother for the delivery of the infant will be approved at the local SRS office and will not require medical records review.

~~SOBRA beneficiaries will have a locally issued card with the statement "for emergency services only" printed on the face of the card.~~ Services may be provided by physicians, dentists, ophthalmologists, laboratories, and radiologists. Allowable places of service are: inpatient hospital, emergency room hospital, office, outpatient hospital, federally qualified health clinic, state or local public health clinic, rural health clinic, ambulance, and laboratory. These services are to stabilize the emergency condition. Follow-up care or treatment for chronic conditions are noncovered.

2200. HEALTHCONNECT Updated 08/08

Introduction to HealthConnect Kansas

HealthConnect Kansas is a program administered by KHPA to allow beneficiaries access to quality medical care in an efficient and economical manner. The HealthConnect Kansas primary care case manager agrees to provide medical care to a select group of KMAP beneficiaries or, when necessary, refer the patient to another provider. In the HealthConnect Kansas Program, primary care case managers (PCCM) are defined as providers who are:

Advanced Registered Nurse Practitioners (ARNP)
Family Practice Physicians
Federally Qualified Health Centers
General Practice Physicians
Indian Health Centers
Internal Medicine Physicians
Local Health Departments
Obstetrics and Gynecology Physicians
Physician Assistant
Pediatric Physicians
Rural Health Clinics
Group practices of the provider types specified

Once a provider has become a PCCM, the provider will be asked to identify the clinical focus for the office. The current provider choice focuses are:

Family Practitioner
Federally Qualified Health Center
General Practitioner with Obstetrics
Local Health Department/Public Health Clinic
Nurse Practitioner
Pediatrician
Physician Assistant
Family Practitioner with Obstetrics
General Practitioner
Internal Medicine
Nurse Midwife
Obstetrics/Gynecologist
Pediatrician and Internal Medicine
Rural Health Clinic

The case manager is paid a monthly fee for each beneficiary assigned to his/her management, plus the established fee-for-service allowance for medical services provided. Beneficiaries are restricted to their assigned case manager and may not receive medical services from other providers without the case manager's approval. The only two exceptions are: 1) emergency services provided in the emergency room, and 2) services exempt from case management referral. The goals of HealthConnect Kansas are to:

- Better manage the beneficiary's use of medical services
- Provide access to primary and preventive medical care by the case manager on a 24 hour a day basis
- Contain costs in KMAP without a reduction in medically necessary services
- Improve continuity of care

2200. Updated 08/08

Primary Care Case Manager
To enroll in the HealthConnect Kansas Program as a primary care case manager (PCCM), contact your managed care provider representative or send a written request regarding enrollment to the HealthConnect Kansas Program:

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

Each HealthConnect Kansas case manager may contract to accept and provide primary care services for ~~a minimum of 10 and~~ up to a maximum of 1800 beneficiaries. If a group enrolls, the total caseload can be 1800 beneficiaries per eligible case manager. The group may choose to accept a lesser number of beneficiaries, simply specify this at the time of enrollment.

Either the case manager or KHPA may cancel the HealthConnect Kansas contract at any time by giving written notice 60 days in advance of the effective date of cancellation. Failure to provide written notice on the part of the case manager will result in forfeiture of monthly case management fees or recoupment of this amount if already paid by KHPA for all months in which the PCCM did not render services.

Providers must not mail materials to beneficiaries directly, solicit beneficiaries to choose the provider as their case manager, or in any way attempt to influence a beneficiary as they choose a PCCM. Failure to comply with this directive may result in KHPA enacting sanctions on the provider.

Enrollment of New Beneficiaries
When beneficiaries become eligible for managed care, they receive an enrollment packet asking them to choose a PCCM from the list of enrolled providers or a health plan (HealthWave 19 – HW19). Only providers who have agreed to become PCCMs and have not reached their chosen beneficiary maximum are available for selection. The beneficiary's primary medical provider can be verified through any of the eligibility verification options. See Section 2000 for complete information on plastic medical cards and eligibility verification. ~~**The beneficiary is not restricted to any provider until their paper medical ID card specifies a primary care case manager in the primary provider field**. The ID card will also have the word "Blue" typed in the lower left hand corner to indicate the beneficiary participates in the managed care program.~~

Beneficiaries in the voluntary populations may choose to participate in the Managed Care Program, but will not be defaulted/auto-assigned if they do not make a choice. The voluntary populations are as follows:

Children with Special Health Care Needs (CSHCN) – must be identified in the interChange MMIS as a child with special health care needs. The Kansas Department of Health and Environment (KDHE) is responsible for the CSHCN program. KDHE sends a file to the interChange MMIS identifying the CSHCN children. The CSHCN indicator in the interChange MMIS is set from the file received from KDHE. CSHCN can also request assignment to a provider outside the managed care program. Many

times this provider is a specialist with a specific set of skills and/or knowledge related to the child's special health condition. There is a special contract these providers sign when agreeing to provide case management to a CSHCN participant. The CSHCN contract allows the provider to participate in the managed care program for one CSHCN child.

SSI Children under the age of 21 – must be identified in the interChange MMIS as a child with an SSI beneficiary population code and under 21 years of age.

Beneficiaries of Native American descent – must be identified in the interChange MMIS as a beneficiary with an American Indian race/ethnicity code.

Beneficiaries in the voluntary populations will be sent a letter annually informing them that their participation in Managed Care is optional.

If beneficiaries meet one of the following exemption criteria they are exempt from Title XIX Managed Care:

- Beneficiary is in the lock-in program.
- Beneficiary has third party liability (TPL) requiring a case manager.
- Beneficiary is participating in one of the Home and Community Based Service (HCBS) programs.
- Beneficiary resides in an adult care home.
- Beneficiary resides in a state institution.
- Beneficiary resides in an intermediate care facility for the mentally retarded.
- Beneficiary resides in a nursing facility for mental health.
- Beneficiary is in foster care.
- Beneficiary is participating in the adoption support programs.
- Beneficiary resides in a head injury rehabilitation facility.
- Beneficiary is enrolled with Medicare, including Qualified Medicare Beneficiary (QMB).
- Beneficiary is participating in the Health Insurance Premiums Payment System (HIPPS) program (exempt from HW 19 only).

~~If a provider is not listed on the beneficiary's Kansas Medical Assistance Program paper ID card, services may be rendered without a referral. (Refer to Section 2000, Item 11, for information on how to identify a HealthConnect Kansas beneficiary.)~~

Established Patients ~~Newborn Eligibility~~

When a practice is at their maximum caseload, they may submit the names of any established patients ~~newborn~~ directly to the fiscal agent on the Enrollment/Disenrollment Form. The form must be completed, including the signature of both the provider and beneficiary or casehead of a minor ~~the newborn~~. This form allows the fiscal agent to override the maximum caseload and add the beneficiary ~~newborn~~ to the caseload without increasing the caseload permanently.

When a practice is not at maximum caseload, the beneficiary ~~newborn's casehead~~ can follow the normal enrollment procedures outlined in the enrollment packet.

2200. Updated 08/08

Regained Eligibility

Any beneficiary who is assigned to a PCCM's practice and loses KMAP eligibility for less than 60 days will be reassigned to the practice once KMAP eligibility is regained, if the practice has available slots. If no slots are available, the beneficiary will have to choose another primary care provider.

If KMAP eligibility lapses for more than 60 days and is then regained after 60 days, the beneficiary will be sent an enrollment packet and will be asked to choose a case manager or health plan through the ongoing process.

Roster of Enrolled Beneficiaries

Each PCCM is provided a monthly roster of Kansas Medical Assistance Program beneficiaries assigned to the practice. The roster is mailed separately from the remittance advice (RA) prior to the upcoming month. The roster contains coverage information for each beneficiary. Due to the Health Insurance Portability and Accountability Act (HIPAA), Third Party Liability (TPL) information is limited. Additionally, KAN Be Healthy (KBH) information can no longer be made available on the roster.

Change of HCK Assignment

Beneficiaries with assigned case managers are allowed to change their case manager at anytime. However, assignment changes can only be processed to take affect at the beginning of a month.

The Enrollment/Disenrollment Form is used to remove beneficiaries from a PCCM's caseload. Provider's requests to disenroll an assigned beneficiary must meet "Good Cause Reasons" and include supporting documentation on the form or in an attached letter. The following are "Good Cause Reasons" that allow a provider to disenroll a beneficiary:

- Beneficiary fails to keep appointments (after counseling)
- Beneficiary is abusive to provider, staff, or other patients
- Beneficiary fails to follow medical advice (after counseling)
- Beneficiary was previously removed from provider's caseload
- Case manager leaves the program
- Fraud

A copy of the Beneficiary Enrollment/Disenrollment Form, sometimes referred to as the 1-to-1 Match Form, is being added to the end of Section 2200 of the *General Benefits Provider Manual*. The manual page version of this form can be copied when providers need additional forms. The completed form and any required documentation and signatures should be faxed to (785) 266-6109.

The Enrollment/Disenrollment Form also allows a PCCM to add beneficiaries when the provider reaches their caseload maximum. This request is considered authorization for the Fiscal Agent to override the maximum caseload. This will not result in a permanent change to the PCCM's maximum caseload.

2200. Updated 08/08

Contract Changes Requiring Notification to Fiscal Agent

Providers who contract with HealthConnect Kansas (HCK) need to notify their Managed Care Provider Representative when a change occurs in any of the following data elements as it relates to HCK participation:

- Tax ID number
- Clinic ownership
- Adding new providers to the office
- Retirement of providers from the office
- Providers going on sabbatical leave
- Closing the practice
- Providers leaving clinic
- Physical address
- Office hours
- Phone number
- Admitting privileges
- Age range of accepted patients
- Covering provider

By contacting the Managed Care Provider Representative prior to a change in any of the above listed elements, a smooth transition for claims payment and beneficiary care is ensured.

Providers Terminating Their HealthConnect Kansas Contract

Providers who wish to terminate their HealthConnect Kansas contract must provide written notice of their intent to terminate to KHPA or the KMAP Fiscal Agent at least 60 days prior to the termination. Failure to provide sixty day written notice of the intent to terminate may result in the recoupment of the last two months of administration payments made to the provider, per the HealthConnect Kansas Contract.

Providers discontinuing care must provide beneficiaries assigned to them medical services or give a referral to another KMAP provider for services, until the beneficiary is no longer assigned to the provider.

Provider Requests To Lower Maximum Caseloads

HealthConnect Kansas PCCM contract providers may request to have their maximum beneficiary caseload reduced by sending written notice to the KHPA KMAP Fiscal Agent at least 60 days prior to the effective date of the reduction. The written notice should be sent to the Managed Care Provider Representative for the provider's county.

HealthConnect Case Manager Responsibilities

Responsibilities of the case manager are outlined in the PCCM contract that is signed by the provider at the time of enrollment. In general, the case manager agrees to:

- Provide the primary health care needs of the beneficiary by performing a physical assessment including a care plan
- Refer the beneficiary to other physicians or providers when necessary
- Monitor the service(s) delivered

2200. Updated 08/08

The beneficiary should only be referred when the case manager is unable to perform a needed service, desires a second opinion, or will no longer be able to provide case management services.

Referrals are required for specified services, however a written referral **form** does not have to be exchanged between providers. All referrals should be documented in the beneficiary's medical record with both the primary care case manager (PCCM) and the receiving medical provider to ensure the service was directed by the PCCM.

The case manager is expected to provide KAN Be Healthy services to beneficiaries under 21 years of age or refer the beneficiary to an appropriate medical provider or specialist as needed. The physician must agree to supervise the screening, diagnosis, and treatment of the beneficiary on an ongoing basis, including administering immunizations as needed. It is encouraged that immunizations be provided at the time of the screen; however, the beneficiary may be referred to the local health department for this service. (Refer to Section 2020 for complete information on the KAN Be Healthy Program.)

Services Requiring Referral from the HealthConnect Primary Care Case Manager

The following non-emergency services are **not covered** if provided or prescribed by a provider other than the assigned PCCM unless the PCCM makes a **referral**:

- ARNP
- Attendant Care for Independent Living (ACIL)
- Audiology
- Dietitian
- Durable medical equipment
- Home health
- Hospice
- Inpatient hospital
- KAN Be Healthy screens (with exception of dental)
- Local health department
- Medical supplies
- Non-CMHC partial hospitalization
- OB care when a beneficiary is assigned to an OB/GYN PCCM
- Podiatry
- Physical therapy
- Physician
- Prosthetic and orthotic items
- Psychiatry/psychology
- Vision surgery services performed in an inpatient setting (requires KBH)

Services Not Requiring Primary Care Case Manager Referral
Any provider may render emergency care in the emergency room due to illness or trauma without a referral from the Primary Care Case Manager (PCCM). Any subsequent, non-emergent care, does require a referral from the PCCM. When billing for care that might be classified as emergent, and the Primary Care Case Manager referral was not secured, the nature of the emergency must be documented in the medical record.

2200. Updated 08/08

The following are common examples of services that **do not** require a referral:

- Adult Care Home
- Alcohol and Drug Abuse Community Based Services
- Ambulance (non-emergency)
- Anesthesia
- Assistant Surgery
- Behavior Management-services outlined in the Behavior Management provider manual
- Community Mental Health Center (CMHC) and non-CMHC affiliate providers
- Dental services including KAN Be Healthy dental screens
- Early Childhood Intervention
- Emergency Room services
- Family Planning
- Home and Community Bases Services (HCBS)
- Immunizations
- Indian Health
- Inpatient services for a primary TB-related diagnosis
- Local Education Agency
- Laboratory
- Maternity Center services
- Newborn home visits
- Pharmacy
- Prenatal Health Promotion and Risk Reduction service
- Psychiatric hospital stays or related physician and ancillary services provided during a psychiatric hospitalization approved through the preadmission assessment process.
- Radiology
- Services provided for a covered pregnancy related diagnosis (on beneficiaries assigned to a primary care case manager other than an OB/GYN or an ARNP specializing in OB/GYN services)
- Services provided in an FQHC
- Sexually Transmitted Disease (STD) services
- State Institution services
- Vision services (other than surgical services performed in an inpatient setting)

2200. Updated 08/08

Referral Requirements

Referrals are required for specified services, however a written referral **form** does not have to be exchanged between providers. Documentation of the referral must be included in both the PCCM and receiving providers' medical records for the beneficiary to ensure the service was directed by the PCCM.

Documentation of the referral must be available for review. Without referral documentation, reimbursement is subject to recovery. It is required that both the referred and referring providers maintain referral documentation in the medical record. Verbal referrals may be given, but must be documented in the medical record. A referral is not needed for emergency room services.

Referral documentation in the PCCM medical record for the beneficiary must include the following information:

- Date of referral
- Reason for referral
- Where beneficiary is being referred
- Scope of referral

Referral documentation in the receiving provider's medical records for the beneficiary must include the following information:

- Name of the referring provider
- Reason for referral
- Date of referral

When a receiving provider refers the beneficiary to additional providers, the PCCM shall be notified to ensure coordination of care with all involved providers. The coordination of care must be clearly documented in the medical records.

2200. Updated 08/08

HealthConnect Kansas Guidelines/Billing Instructions

Emergency Admissions
When inpatient services are the result of an emergency, documentation shall be maintained in the medical record supporting the nature of the emergency. Place the attending physician's Medicaid provider number in the first occurrence of field 76 on the UB-04 claim form. Providers should reference their electronic media resources to determine corresponding electronic claim fields.

Inpatient Admissions
When a PCCM admits his/her own patient, place the PCCM provider number in the "attending physician" field.

If another physician, who has received a referral from the PCCM, is admitting the beneficiary, the hospital must have documentation in the medical record supporting the PCCM's assent for inpatient services. The "referring physician" field on the claim is not required.

Outpatient Services
Documentation in the hospital outpatient medical record must indicate the HealthConnect Kansas case manager's approval and the statement shall be signed by the individual who received the approval. If the HealthConnect Kansas provider cannot be reached, approval must be secured from one of his/her covering providers.

Peer Education and Resource Council (PERC)
The Peer Education and Resource Council (PERC) assists with provider education, development and review of improvement plans for providers, peer review, and recommendations for policy change. PERC is composed of Health Care Policy Medical Policy (HCPMP) representatives, fiscal agent representatives, and at least six enrolled KMAP providers. Providers on the council are chosen by HCPMP and represent a cross section of providers from across the State of Kansas.

2210. HEALTHWAVE XIX KANSAS Updated 08/08

HealthWave XIX offers eligible Medicaid beneficiaries the choice to have their primary health needs provided through a physical health managed care organization (MCO) which serves as their primary care provider. Beneficiaries assigned to one of the medical MCO plans will receive both a plastic State of Kansas Medical Card and a card from the MCO plan. Providers should use both cards when verifying eligibility and coverage.

HealthWave XIX is available to adults and children under the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) women and children in active counties. ~~Beneficiaries who choose to become members of an MCO participating in the HealthWave XIX program are issued a monthly paper medical ID card. This card will have the word 'BLUE' typed on the bottom of it and will identify the MCO as the primary care case manager.~~

Individuals excluded from the HealthWave XIX Program are:

- Beneficiaries with Medicare coverage.
- Beneficiaries enrolled in another managed care program (e.g., HealthConnect).
- Beneficiaries who have another third party insurance with an MCO or case manager.
- Beneficiaries residing in a:
  - nursing facility.
  - state institution.
  - nursing facility for mental health (NF/MH).
  - head injury rehabilitation facility (HIRF).
  - an intermediate care facility for the mentally retarded (ICF/MR).
- Beneficiaries enrolled in any HCBS program.
- Beneficiaries enrolled in the Health Insurance Premium Payment Service (HIPPS) program.
- Beneficiaries in the lock-in program.
- Beneficiaries eligible for foster care.
- Beneficiaries eligible for adoption support programs.
- Beneficiaries eligible for the breast and cervical cancer program.
- Beneficiaries enrolled in the working healthy program.

Excluded Services

The physical health MCO provides all primary health services and necessary, specialty services to its members, except for the services listed below. Some restrictions may apply. These are covered through Medicaid's traditional fee-for-service programs or another managed care organization.

- ~~Abortions (Abortions are only covered by Medicaid if the abortion is a result of incest, rape, or if the pregnancy is endangering the life of the mother.)~~
- Alcohol and drug abuse services, except for medical detoxification in a hospital
- Services provided in a community mental retardation center
- Dental services, except for inpatient dental

2210. Updated 08/08

Excluded Services cont.

- Long term care services:
  - Services provided in a nursing facility
  - Home and community-based services (HCBS)
  - Services provided in an ICF/MR
  - Services provided in a nursing facility for mental health
  - Services provided in a head injury rehabilitation facility
- Mental health services, including services by a psychiatrist or psychologist, community mental health center, partial hospitalization, and behavior management
- Services provided in a State psychiatric institution

Covered HealthWave XIX MCO Services:
The following are the minimum services the MCO will provide. These services will be available to beneficiaries in the MCO's service area. Services may be provided by the MCO or through the MCO's subcontractors.

- Audiology and hearing
- Blood transfusions
- Chiropractic for KAN Be Healthy participants only
- Contraceptives
- Dietary
- Durable Medical Equipment
- Emergency services
- Family planning services
- Home health services
- Home visits for the newborn, including risk assessment of the newborn, instruction in parenting practices, and referral to other support services, if needed. One home visit per beneficiary within 28 days after the birth date of the newborn
- Hospice
- Inpatient hospital, including acute medical detoxification and inpatient dental.
- Laboratory services that meet Clinical Laboratory Improvement Act standards
- Medical supplies
- Mental health medications
- Services provided by a Mid-level practitioner
- Occupational therapy
- Outpatient hospital services
- Podiatry services for KAN Be Healthy participants only
- Pharmaceuticals, all except blood fractions
- Physical therapy
- Services provided by a physician
- Prenatal health promotion and risk reduction (risk assessment, counseling, instruction in prenatal care practices, including methods to control risk factors, instruction in effective parenting practices, referral to other support, if needed, and follow up)

2210. Updated 08/08

Covered Services cont.

- Radiology (X-rays)
- Screening, diagnosis and treatment of sexually transmitted diseases
- Speech therapy
- Transportation, emergency and nonemergency
- Vision
- KAN Be Healthy (EPSDT) services, screenings as well as medically necessary KAN Be Healthy extended services

Transportation Services:
Depending on a beneficiary's benefit plan, commercial non-emergency medical transportation services may be covered or noncovered. If a beneficiary is assigned to a managed care organization (MCO), commercial non-emergency medical transportation services are the responsibility of the beneficiary's assigned MCO.
If a beneficiary has the following benefit plans, he or she qualifies for commercial non-emergency medical transportation services:

- TXIX (Title 19)
- QMB (qualified Medicare beneficiary) and TXIX

If a beneficiary has the following benefit plans, he or she does not qualify for commercial non-emergency medical transportation services:

- QMB only
- MediKan

If a beneficiary has eligibility for one of the following, he or she should be instructed to contact his or her assigned MCO to obtain commercial non-emergency medical transportation services:

- HW19 (HealthWave 19-MCO Title XIX)
- HW21/TXXI (HealthWave 21)

Trips excluded:

- Trips to WIC clinics or to pick up durable medical equipment
- Trips to local education agencies
- Trips to educational classes or day care services
- Errands or shopping
- Trips to pick up glasses, medical equipment or prescriptions

Note: You can still stop on the way home from your doctor to pick up a prescription as long as it is on the way and doesn't cost extra to get there.

- Trips to attend nutrition, diabetic or other informational classes
- Trips for noncovered services like breast enhancement or weight management

Sterilizations:
The Medicaid MCOs are responsible for payment of sterilizations. The MCOs must ensure that a completed sterilization consent form is available upon request.

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

2300. BORDER CITY/OUT-OF-STATE PROVIDERS Updated 08/08

When a provider is located in a state other than Kansas, and services are rendered in that state, the provider must be licensed and otherwise certified by the proper agencies in his/her state of residence as qualified to render the services for which the charge is made. Certain cities, within 50 miles of the Kansas border, may be closer for Kansas residents than major cities in Kansas, and therefore these cities are considered Border Cities (see list below). This list is not all inclusive. All others are considered Out-of-State and require PA. (Refer to Section 4300.)

ARKANSAS
Bentonville
Gateway
Gravette
Rogers

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

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

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

MISSOURI(cont.)
Warrensburg
Webb City

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

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

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

2400. PROGRAM INTEGRITY Updated 08/08

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

Goals of the Medicaid quality management program are to:

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

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

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

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

Standards of Care
Standards of care utilized by Medicaid include nationally recognized standards such as those recommended by the American Academy of Pediatrics regarding well-child visits which pertain to the Medicaid KAN Be Healthy program. (See Section 2020 for more information)

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

2400. Updated 08/08

Medicaid also recommends initial prenatal visits occur as follows:

- First trimester--visit within fourteen (14) days of first request
- Second trimester--visit within seven (7) days of first request
- Third trimester--visit within three (3) days of first request
- High risk pregnancies--visit within three (3) days of identification of high risk

Other standards utilized by Medicaid in the HealthWave XIX Kansas and HealthConnect Kansas Programs include:

- Consumers must have 24 hour access 7 days a week to medical advice.
- In-office appointment wait times do not exceed two hours from the time of the scheduled appointment.
- Urgent care appointments are provided within two (2) days of when the beneficiary presents or calls with symptoms of sudden or severe onset.
- Routine preventive care appointments (non-KAN Be Healthy) are made available within 45 days of the beneficiaries' request.
- 85% of a provider's KAN Be Healthy (KBH) population is up-to-date on KBH screens for those consumers who have been with the provider for one or more years.
- Remedies/corrective action plans are responded to by the provider within the timeframes requested.

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

Provider Satisfaction Surveys
Written surveys occur on a yearly basis and are sent to all providers in the HealthConnect Kansas or HealthWave XIX Kansas programs. The intent of these surveys is to obtain feedback from providers in regard to program implementation and suggestions for improvement in program policies or processes.

Consumer Satisfaction Surveys
Yearly random sample telephone surveys are completed to determine the level of consumer satisfaction with the program in regard to access, quality of care and barriers to obtaining services.

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

2400. Updated 08/08

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

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

Committees
The Peer Education and Resource Council (PERC) - PERC is a group of currently practicing Medicaid health care providers whose purpose is to provide clinical and program education to HealthConnect Kansas providers and to recommend policy initiatives to the Medicaid program which enhance quality and access to services while controlling costs.

External Quality Review Advisory Committee - This advisory committee consists of medical directors from each of the participating HMOs, a PERC and Drug Utilization Review Board member and staff from within the Department of Health and Environment. The purpose of this committee is to assist Medicaid in developing, implementing and evaluating outcome based studies across all Medicaid programs.

Fraud and Abuse:

Consumer
The SRS Legal Fraud Unit is responsible for the investigation and prosecution of consumer fraud. The Fraud Unit operates a 24-hour, toll-free fraud hot line telephone service, 1-800-432-3913. Suspected cases of consumer fraud (including the abuse of the medical ID card) should be immediately reported via the hot line.

2400. Updated 08/08

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

Normally a beneficiary will be locked-in to a pharmacy, physician, and/or hospital. In some cases, the beneficiary may be locked-in to all of these.

~~Lock-in information is printed on the Medicaid paper ID card as illustrated in Section 2000.~~ Lock-in information is ~~also~~ available through BEVS via AVRS or POS system. See Section 2000 for complete information on plastic medical cards and eligibility verification.

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

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

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

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

2400. Updated 08/08

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

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

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

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

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

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

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

Pharmacy: Enter the lock-in physician's 10 digit Kansas Medicaid provider number or NPI in the prescribing physician field for point of sale claims if the lock-in provider is the prescribing physician. If prescription privileges were referred, a paper claim must be submitted with the lock-in provider's number in the "Remarks Field" or a written referral attached to the claim.

2400. Updated 08/08

Physician: Enter the KMAP lock-in provider number in field 17A of the CMS-1500 claim form **unless:** 1) the billing/performing provider is the lock-in provider, or 2) filing claims for radiologists or pathologists.

Hospital: Enter the KMAP lock-in physician's provider number in FL 76 of the UB-04 claim form.

Provider

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

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

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

Complaint/Grievance Process:

Medicaid consumers and providers who have concerns regarding access to care, utilization of services, quality of services, or rights and dignity can contact the fiscal agent at 1-800-933-6593 (in-state providers) or (785) 291-4145 (Topeka area providers) between 7:30 a.m. - 5:30 p.m., Monday through Friday. Concerns will be carefully evaluated and directed to the appropriate staff for research, follow-up, and action if needed. You will be notified of the outcome.

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

For issues concerning potential consumer fraud, please contact the fraud hotline at 1-800-432-3913.

2500. STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH PROVIDERS
Updated 08/08

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

Upon notification of intent to withdraw payment liability for services rendered, or to terminate participation in the Kansas Medical Assistance Program, the provider of services has the opportunity for an Administrative Review. If after the administrative review, the provider continues to disagree with the determination, a subsequent fair hearing may be requested with a hearing officer at KHPA.

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

- Pattern of submitting inaccurate billings or cost reports;
- Pattern of unnecessary utilization;
- Civil or criminal fraud against the Kansas Medical Assistance Program or Social Service Programs or any other state's Medicaid or Social Service Programs;
- Suspension by the Secretary of Health, and Human Services from the Title XVIII program for any reason;
- Direct or indirect ownership or controlling interest of five percent (5%) or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the Medicare Program or the Kansas Medical Assistance Program or Social Service Programs or any other state's Medicaid or Social Service Programs;
- Employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the Medicare Program or the Kansas Medical Assistance or Social Service Programs or any other state's Medicaid or Social Service Programs; and other "good cause."

2600. REPORTING OF ABUSE, NEGLECT OR EXPLOITATION OF CHILDREN OR RESIDENTS IN ADULT CARE HOMES-REQUIRED Updated 08/08

Who Must Report:

- Any person licensed to practice any branch of the healing arts
- The chief administrative officer of a medical care facility
- An adult care home administrator
- A licensed social worker
- A licensed professional nurse
- A licensed practical nurse

Any other person having reasonable cause to suspect or believe that a child or ACH resident is being or has been abused, neglected, exploited or is in a condition which is the result of such abuse, neglect, exploitation or is in need of protective services may report such information to their local SRS office.

Adults

Upon receipt of reports of abuse, neglect or exploitation in adult care homes or medical care facilities (hospitals), SRS shall refer all such complaints to the Department of Health and Environment. The complainant should be given the toll-free hot line number of Health and Environment, **1-800-842-0078**. Complaints received in writing shall be forwarded to:

Department of Health and Environment
Complaint Coordinator
Landon State Office Bldg., Suite 1001
900 S.W. Jackson
Topeka, Kansas 66612

Children

Reports of abuse, neglect or exploitation of children shall be referred to SRS Children and Family Services. The complainant should be given the toll-free hot line number of Children and Family Services, **1-800-922-5330**.

What Must Be Reported:

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

2600. Updated 08/08

Immunity of Reporter:

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

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

How To Report:

Call Kansas Department on Aging at **1-800-842-0078** regarding reports of abuse, neglect or exploitation in adult care homes or licensed care facilities (hospitals), go in person, or write your local SRS office.

Call **1-800-922-5330** regarding abuse, neglect or exploitation of children, go in person, or write your local SRS office.

2700. DOCUMENTATION REQUIREMENTS Updated 08/08

Claim/Record Storage Requirements:

K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and Lock-In referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims via computerized systems (i.e., tape) must maintain these records in a manner which is retrievable as follows:

- A hard copy printout or readable copies from microfilm and microfiche.
- If the required records are retained on machine readable media (i.e., tape), a hard copy of the record must be made available when requested.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers (a) to keep such records as necessary to disclose fully the extent of services rendered to beneficiaries, and; (b) to furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider.

Providing medical records to the Kansas Medical Assistance Program or its designee is not a billable charge.

Documentation Requirements:

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

- The patient record shall be legible and **stand on its own**.
- The date and reason for a service must be included.
- Extent of the patient history and exam must be documented along with a treatment plan.
- Documentation must support the level of service billed.
- Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp which reflects results of the exam for each of the systems identified on the rubber stamp.
- Unless permitted by specific HCBS Program guidelines, **check marks are not accepted**.
- Records must be created **at the time the service is provided**.

2700. Updated 08/08

Progress notes shall include:

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

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

1) Is the reason for the visit documented in the patient record?
2) Are all services that were provided documented?
3) Does the patient record clearly explain why support services, procedures, supplies and medications were or were not provided?
4) Is the assessment of the patient's condition apparent in the record?
5) Does documentation contain information on the patient's progress and results of treatment?
6) Does the patient record include a plan for treatment?
7) Does information in the patient record provide medical rationale for the services and the place of service that are to be billed?
8) Does information in the patient record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services? Is there documentation of timely referrals?

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

Electronic Documentation Signature

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

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

The use of an electronic signature is deemed to constitute a signature and has the same effect as a written signature on a document.

2700. Updated 08/08

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

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies.

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.

Original signatures are still required on provider enrollment forms.

Electronic Documentation

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

- Meet all documentation and signature requirements contained in the *General Benefits Provider Manual*
- Meet all documentation and signature requirements specific to the KMAP program and services provided
- Assure the documentation cannot be altered once entered
- Maintain a system to document when records are created, modified or deleted to provide an audit trail

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

Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.

Note: Documentation can be requested at any time to verify that services have been provided within program guidelines.

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

2700. Updated 08/08

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

2710. GENERAL THERAPY GUIDELINES AND REQUIREMENTS Updated 09/09

Therapy services are covered when they are:

- Prescribed by a physician, as required by your license/certification.
- Medically necessary.
- Habilitative - Habilitative therapy is covered only for participants age zero to under the age of 21. Therapy treatments approved and provided by an Early Childhood Intervention (ECI), Head Start or Local Education Agency (LEA) program may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to maintain maximum possible functioning for children.
- Rehabilitative - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following debilitation due to an acute physical trauma or illness.
- Provided by a licensed physical or occupational ~~registered~~ therapist or a certified therapy assistant, working under the direct supervision of a licensed physical or occupational ~~registered~~ therapist. When services are performed by a certified therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed physical or occupational ~~registered~~ therapist initialing each treatment note written by the certified therapy assistant, or the licensed physical or occupational ~~registered~~ therapist writing "treatment was supervised" followed by his or her signature.

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

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

Documentation requirements of therapy services:

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

Please refer to your specific provider manual for additional benefits and limitations.

2720. TELEMEDICINE Updated 06/09

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

Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the codes listed below using the GT modifier and will be reimbursed at the same rate as face-to-face services. The originating site, with the beneficiary present, may bill code Q3014.

90801GT	90804GT - 90809	90847GT
90862	99201GT - 99205GT	99211GT - 99215GT
99241GT - 99245GT	99251GT -99255GT	99261GT - 99263GT
99271GT - 99275GT	H0001GT	H0004GT
H0005GT	H0006GT	H0007GT
H0038GT	H0038HQGT	

LIMITATIONS

- The patient (beneficiary) must be present at the originating site.
- E-mail, telephone and facsimile transmissions are not covered as telemedicine services.
- Documentation requirements are the same as face-to-face services per Section 2710, General Therapy Guidelines and Requirements.

2800. HOSPICE Updated 08/08

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

Waiver of Rights to Medicaid Payment:

The consumer waives all rights to Medicaid/MediKan payments for the duration of the election of hospice care for the following services:

Any Medicaid/MediKan covered services that are: 1) related to the treatment of the terminal condition for which hospice care was elected or a related condition, or 2) equivalent to hospice care **except** for services:

- Provided directly or under arrangement by the designated hospice.
- Provided by another hospice under arrangement by the designated hospice.
- Provided by the consumer's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Services Not Related to the Terminal Illness:

Services normally covered under the Kansas Medical Assistance Program require prior authorization (PA) when the consumer is a hospice consumer and the service does not relate to the terminal illness. Refer to Section 4300 for information on obtaining PA.

2900. CHILDREN AND FAMILY SERVICES (CFS) CONTRACTORS Updated 08/08

Medicaid mental health reimbursable services will not be paid by child welfare contractors. Covered services will either be paid on a fee for service basis or through the Prepaid Ambulatory Health Plan (PAHP) coverage.

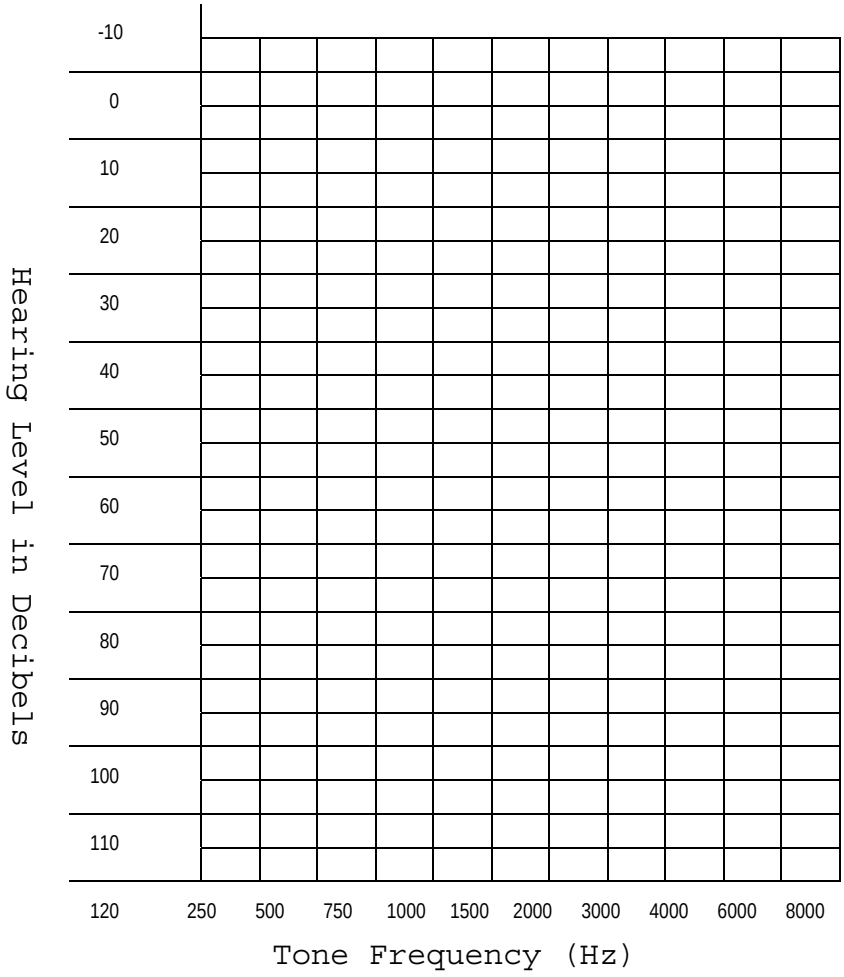
FORMS

AUDIO SCREENING FORM

KAN BE HEALTHY ALL AGES SCREENING FORM

MANDATORY BLOOD LEAD SCREENING QUESTIONNAIRE

REQUISITION FOR LABORATORY SPECIMEN KITS



AUDIO SCREENING

Name:_____

Date of Birth:_____

Sex:_____

Screen Date:_____

Screener:_____

Symbols

Ear	Response	No Response	Ear Phone
Left	X	△	Blue
Right	O	☆	Red

Risks(hobbies, job exposure):

_____

_____

Comments:

_____

_____

KAN Be Healthy (EPSDT) Screening Form

I.D. Number:_____

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T _____ P _____ R _____ BP _____

Weight _____ (lbs/kg) _____ th%

Length (Birth to 24 months) _____cm/in

BMI _____

BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

Weight/Length _____ %

Standing Height (2 - 20 years) _____ cm/in

_____ th%

Male ☐ **Female** ☐

Head Circ (≤ 24 months) _____ cm/in _____ th%

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.
☐ No changes in medical Hx unless indicated.
☐ Previous Hx reviewed from_____ visit.
☐ Patient currently in Foster care, no previous hx available.

Present Concern: _____

Medications: _____

Serious Illness/Accidents: ☐ No ☐ Yes (date & type)
(including Hospital or ER visits)

Allergies (food & drug) _____

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐ Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

Allergies (food & drug)		Drug or ETOH Abuse		Mental Illness	
Asthma		Earaches		Obesity	
Birth defects		Epilepsy/Seizures		Scoliosis/Arthritis	
Blood Disorder/ Sickle Cell		Headache		Speech, Visual, Hearing	
Cancer		High Blood Pressure		Ulcers/Colitis	
Colds/sore throat		Kidney/Liver Disease		Urinary/Bowel	
Diabetes		Lung Disease		Heart Disease/Stroke	

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	Lung sounds?
Cardiovascular	☐	☐	Murmur?
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Ages 0 to 3 yr - Corneal Light Reflex Present: Yes ☐ No ☐
Ages 3 yr thru 20 - Bruckner Exam: Pass ☐ Refer ☐
All ages - Outer Inspection: Normal ☐ Abnormal ☐
Eye Tracking: Pass ☐ Refer ☐ PERRLA: Pass ☐ Refer ☐
Ocular Motility(strabismus/cross cover test): Pass ☐ Refer ☐

Ages 3 thru 20:
.Distance Acuity - Tool used:_____ Score: L R Both
Near Acuity - Tool used: _____ Score: L R Both
Last exam:_____ Further comments (see below)

NUTRITION

☐ WIC participant
☐ Referred to WIC
☐ Breast Feeding ☐ Formula
Amount & how often: _____
Number of Servings per day

Bread/Cereal	_____	Dairy	_____
Fat/Sweet/Sugar	_____	Fruit	_____
Meat/Bean/Egg	_____	Vegetable	_____
Fluid Intake: water	_____ oz.	Soda	_____
Milk	_____ oz.	Juice	_____

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside
☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)
☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No
If "yes", then complete following :
1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No
Referred to:

LABORATORY

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes ☐ No ☐ Indicate further follow-up in Plan of Care.

DEVELOPMENTAL / EMOTIONAL

Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.
Children < 6 yrs. A completed developmental screening tool **to include the screener's interpretation and report** regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care.

Children 6-21 yrs. A completed developmental screening tool **to include the screener's interpretation and report** or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care.

Developmental Tool used:_____

Sleep Habits	_____	Tired / overactive?	_____
Discipline:	_____	Vocational concerns?	_____
Peer Interaction:	_____	Exercise	_____
Grade Level	_____	Average Marks	_____
Special Education:	_____	Special Needs:	_____

Any emotional or behavioral problems? _____
Emotional Observations:_____

IMMUNIZATIONS

Copy of record in chart
Current ☐
Behind ☐
Unknown ☐
Requested from Parent ☐
Referred to VFC provider ☐

Needs (circle): Rota HepB DTaP Flu Hib IPV MMR MCV4 MPSV4 PCV Varicella HepA HPV Other:

DENTAL

Sees Dentist? Yes ☐ No ☐
Last dental exam date: ____/_____/_____
times brushes/day: _____
Dental Referral (annually at a minimum 1-20yr)
Yes ☐ No ☐ ~ Fluoride Varnish? Yes ☐ No ☐

HEARING SCREEN

Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report.

Age birth to 4, perform Risk Indicators for Hearing Loss **and** Hearing Developmental Scales Pass ☐ Refer ☐
Hearing Health History >4: Pass ☐ Refer ☐
Or Screen Procedure:_____

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline	5. Family Planning	9. Parenting	13. Self Breast Exam
2. Oral /Dental	6. Immunizations	10. Safety/Poisons	14. Sexuality
3. Development	7. Lifestyle	11. Substance Abuse	15. Exercise
4. Physical Activity	8. Nutrition	12. Self Testicular Exam	16. Weapon Safety

17. Other:_____

RESULTS/PLAN OF CARE

Screening Results: _____

Plan/Referrals (dental, vision, hearing, dietary, etc):_____

Recommended Return Date:

Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes ☐ No ☐
Parent/Caregiver and/or Patient Signature:_____
Date: _____

Screening Providers Signature: _____

(Licensed Physician, ARNP, PA, or Registered Nurse credentialed to perform KAN Be Healthy screens)

form revised 12/6/07

Mandatory Blood Lead Screening Questionnaire

To be completed at each KBH Screen from 6 to 72 months

Does your child: (circle response received) **DATE**: (MM/DD/YYYY)							
1) **Live in or visit a house or apartment built before 1960?** (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
2) **Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
3) **Have a family member with an elevated blood lead level?**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
4) **Interact with an adult whose job or hobby involves exposure to lead?** (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery).	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
5) **Live near a lead smelter, battery plant or other lead industry?** (Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work).	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
One positive response to the above questions <u>requires</u> a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**
Interviewing Staff Initials						

Staff Signature:

Patient Name: _____ I.D. Number: _____;

Revised 12/2007

Cuestionario Obligatorio para Examen de Plomo en la Sangre

Debe ser completado en cada examen de KBH de 6 a 72 meses

Su hijo: (circule la respuesta recibida)	**FECHA:** (MM/DD/YYYY)						
1) ¿**A vivido en o visitado una casa o apartamento construido antes del 1960?** (Esto puede incluir una guardería, preschool, la casa de su niñera o un pariente, etc.)		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
2) ¿**A vivido en o visitado regularmente una casa o apartamento construido antes del 1960 que este, aya estado, o vaya estar bajo renovación o remodelación?**		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
3) ¿**Tiene un pariente con un alto nivel de plomo en la sangre?**		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
4) ¿**Tiene comunicación con un adulto que trabaje o que tenga un pasatiempo que involucre la exposición a plomo?** (acabado de muebles, haciendo vidrio manchado, electrónicos, soldando, reparación automotriz, haciendo pesas o señuelos para pescar, cargando casquillos o balas en una escopeta, disparando armas, haciendo reparos o remodelaciones, pintando/desmontando pintura, juguetes antiguos o importados, y/o haciendo cerámica).		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
5) ¿**A vivido cerca de un fundidor de plomo, planta de baterías u otra industria de plomo?** (parque/explosivos, reparación de auto/exterior de auto, quitando o juntando cable/alambre, produciendo cables, cerámica, rango de disparos, fabrica de vidrio plomado, maquinaria/equipo industrial, maquinaria o reparación de joyas, mina de plomo, fabricante de pintura/pigmento, plomería, reparación de radiador, yunque de metal o baterías, hierro o metal, o fundidor derretido		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
6) ¿**Usa trastes cristalinos o de cerámica para cocinar, comer o beber?**		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
Una respuesta positiva a estas preguntas <u>exige</u> obtener el nivel de plomo en la sangre. Por favor, recuerde que el nivel de plomo en la sangre es obligatorio a los 12 y 24 meses, aunque las respuestas no sean positivas. ¿Se obtuvo el nivel de sangre?		**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**	**Sí** **No**
Iniciales de Personal que dio la entrevista							

Firma de Personal:

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE AS INDICATED

Nombre del Paciente: _____ Numero de ID: _____;

DIVISION OF HEALTH AND ENVIRONMENTAL LABORATORIES
DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field, Building 740
Topeka, Kansas 66620-0001

REQUISITION FOR LABORATORY SPECIMEN KITS

Please use the appropriate kit listed below to submit specimens to the Health and Environmental Laboratories. Each kit consists of a specimen container, an addressed mailing container, and a kit requisition form. Order the Universal Specimen Submission forms in the space below. If you have any questions about submitting specimens, please refer to the Manual of Laboratory Tests or call (785) 296-1623. Please enter the quantity needed on the line next to the item.

RUSH ORDERS: FAX to (785) 296-1641

Universal Specimen Submission Forms Only

_____ Specify number required

Serology

_____ Multi-tube bottle with mailing box (5 tube box)

_____ Blood Tubes (Yellow Top)

_____ Chlamydia/Gonorrhea Mailer

Viral Culture

_____ Virus VTM (HD and Influenza

_____ Flu VTM Surveillance Sites Only)

Parasite (O & P)

_____ Feces Mailer

_____ Pinworm (Health Departments Only)

Gonorrhea

_____ Culture Plates

_____ Mailer, for two specimens

_____ CO_2 Tablets

_____ Whirl-Pak Bag

Inorganic Chemistry

_____ Blood Lead Filter Paper Forms

_____ Blood Lead Confirmation Kits

_____ EDTA (Purple Top) Blood Tubes

Neonatal Screening

_____ Initial (Green) Collection Unit - ☐ Eng ☐ Span

_____ Repeat (Red) Collection Unit - ☐ Eng ☐ Span

Bacterial

_____ Enteric Mailer

_____ Miscellaneous Infectious Disease (IDS) Shipper

TB

_____ Sputum Mailer

Pertussis

_____ Pertussis Mailer

Other

_____ (Specify):_____

Contact Epidemiologic Services at (877) 427-7317 first for AIDS C/T test, Prenatal tests and WNV tests

Send to:
Facility ID No. : _____

Facility Name: _____

Attn: _____

Address: _____

City: _____ **, KS** _____

Phone: _____

LAB USE ONLY

Order Number: _____

Date Received: _____

Date Shipped: _____

Shipped By: _____