



KANSAS MEDICAL ASSISTANCE PROGRAM
Provider Manual

HCBS
Mental Retardation or Other
Developmental Disabilities

**PART II
HCBS MRDD PROVIDER MANUAL**

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INTRODUCTION TO THE HCBS MRDD PROGRAM

Updated 07/12

The Home and Community Based Services (HCBS) for Mental Retardation or Other Developmental Disabilities (MRDD) program is designed to meet the needs of beneficiaries who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution. It is the beneficiary's choice to participate in the HCBS program.

- Assistive Services
- Day Supports
- Financial Management Services*
- Medical Alert-rental
- Overnight Respite
- Personal Assistant Services
- Residential Supports
- Sleep Cycle Support
- Specialized Medical Care
- Supported Employment
- Supportive Home Care
- Wellness Monitoring

* Refer to the *HCBS Financial Management Services Provider Manual* for criteria and information.

All HCBS MRDD waiver services require prior authorization through the plan of care (POC) process.

Money Follows the Person Program

Money Follows the Person (MFP) services are available to qualified beneficiaries. These services are specific to beneficiaries transitioning into the community from designated institutional settings. Refer to the *Money Follows the Person Provider Manual* for criteria and additional information.

HCBS MRDD Enrollment

HCBS MRDD providers must enroll and receive a provider number for HCBS MRDD program services. Access provider enrollment information at <https://www.kmap-state-ks.us/Public/Provider.asp>.

Miscellaneous Documentation

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

Notes in AuthentiCare

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

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

INTRODUCTION TO THE HCBS MRDD PROGRAM

Updated 09/11

HIPAA Compliance

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

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

7000. MRDD ASSISTIVE SERVICES BILLING INSTRUCTIONS Updated 07/12

Introduction to the CMS-1500 Claim Form

Providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services provided under KMAP. Any CMS-1500 claim form not submitted on the red claim form will be returned to the provider. An example of the CMS-1500 claim form is:

- On the public website at <https://www.kmap-state-ks.us/Public/forms.asp>
- On the secure website at <https://www.kmap-state-ks.us/provider/security/logon.asp>

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

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

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the *General Billing Provider Manual*.

Submission of Claim

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

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

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

- Overnight Respite
- Personal Assistant Services
- Sleep Cycle Support
- Specialized Medical Care (RN)
- Specialized Medical Care (LPN)
- Financial Management Services

7010. HCBS MRDD SPECIFIC BILLING INFORMATION Updated 06/11

ASSISTIVE SERVICES

Enter procedure code **S5165** in field 24D of the CMS-1500 claim form.

One unit equals one service.

DAY SUPPORTS

Enter procedure code **T2020** in field 24D of the CMS-1500 claim.

One unit equals one day.

MEDICAL ALERT

Enter procedure code **S5161** in field 24D of the CMS-1500 claim form.

One unit equals one month.

OVERNIGHT RESPITE

Enter procedure code **H0045** in Field 24D on the CMS-1500 claim form.

One unit equals one day.

PERSONAL ASSISTANT SERVICES

Enter procedure code **T1019** in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

RESIDENTIAL SUPPORTS

Enter procedure code **T2016** in field 24D of the CMS-1500 claim.

One unit equals one day.

SLEEP CYCLE SUPPORT

Enter procedure code **T2025** in field 24D of the CMS-1500 claim form.

One unit equals a minimum of eight hours up to a maximum of 12 hours.

SPECIALIZED MEDICAL CARE

Enter procedure code **T1000** in field 24D of the CMS-1500 claim form for a licensed practical nurse (LPN).

Enter procedure code **T1000 with modifier TD** in field 24D of the CMS-1500 claim form for a registered nurse (RN).

One unit equals 15 minutes.

SUPPORTED EMPLOYMENT

Enter procedure code **H2023** in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

SUPPORTIVE HOME CARE

Enter procedure code **S5125** in field 24D of the CMS-1500 claim form.

One unit equals 15 minutes.

WELLNESS MONITORING

Enter procedure code **S5190** in field 24D of the CMS-1500 claim form.

One unit equals one visit per 60 days.

7010. HCBS MRDD SPECIFIC BILLING INFORMATION Updated 08/12

Client Obligation

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

Third-Party Liability

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

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

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

One Plan of Care per Month

Prior authorizations through the POC process are approved for one month only. Dates of service that span two months must be billed on two separate claims.

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

Overlapping Dates of Service

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

Same Day Service

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

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

8400. BENEFITS AND LIMITATIONS Updated 06/11

HCBS MRDD program services are designed to prevent beneficiaries from entering, or remaining, in an intermediate care facility for mental retardation (ICF/MR).

ASSISTIVE SERVICES

Assistive services are supports or items that meet a beneficiary's assessed need by improving and promoting the person's health, independence, productivity, or integration into the community. They are directly related to the beneficiary's person-centered support plan (PCSP) with measurable outcomes. Examples include, but are not limited to, wheelchair modifications, ramps, lifts, modifications to bathrooms and kitchens (specifically related to accessibility), and assistive technology (items that improve communication, mobility, or assist with activities of daily living or instrumental activities of daily living in the home and workplace).

The assistive service must do one of the following:

- Increase the beneficiary's ability to live independently
- Increase or enhance the beneficiary's productivity
- Improve the beneficiary's health and welfare

ASSISTIVE SERVICES LIMITATIONS

General Limitations

- HCBS MRDD Assistive Services are available to Medicaid beneficiaries who:
 - Are five years of age or older
 - Are mentally retarded or otherwise developmentally disabled
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD program services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through requirements relating to the deeming of parental income and who meet the criteria above.
- All assistive services must be purchased under the beneficiary's or respective guardian's written authority, must be paid to either the community developmental disability organization (CDDO) or an entity qualified by the CDDO, and must not exceed the prior authorized purchase amount.
- Purchase or rental of used assistive technology is limited to those items not covered through regular Medicaid.
- An outside party cannot be required to subsidize an assistive service request. The contractor must accept full payment from Medicaid.

Specific Limitations for Wheelchair Modifications

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

8400. BENEFITS AND LIMITATIONS Updated 07/12

ASSISTIVE SERVICES

ASSISTIVE SERVICES LIMITATIONS

Specific Limitations for Van Lifts (including repair and maintenance)

- Van lifts purchased must meet any engineering and safety standards recognized by the secretary of the U.S. Department of Transportation.
- Van lifts can only be installed in family vehicles or vehicles owned or leased by the beneficiary. A van lift must not be installed in an agency vehicle unless an informed exception is made by the Disability and Behavioral Health Services/Community Supports and Services (DBHS/CSS).

Specific Limitations for Communication Devices

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

Specific Limitations for Home Modifications

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

Signature Limitations

When choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided knowing the beneficiary may have limitations. A designated signatory can be anyone aware of the services provided. However, the individual providing the services **cannot** sign the time sheet on behalf of the beneficiary.

Each time sheet must contain the signature of the beneficiary or designated signatory verifying the services received and the time recorded. Approved signing options include:

- Beneficiary's signature
- Beneficiary making a distinct mark representing his or her signature
- Beneficiary using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider must establish, document, and monitor a plan based on the situation.

8400. BENEFITS AND LIMITATIONS Updated 09/11

ASSISTIVE SERVICES

ASSISTIVE SERVICES PROVIDER REQUIREMENTS

- All providers must be State of Kansas enrolled Medicaid providers.
- Beneficiaries will be permitted to purchase assistive service item(s) from any available agency in their community who is either a CDDO, an agency qualified by the CDDO, or an affiliate of the CDDO. The specified item must be provided as identified in the PCSP.
- Agencies contracted to provide home modifications include contractors and/or agencies licensed by the county or city in which they work (if required by the county or city), and they must perform all work according to existing local building codes.
- Assistive services require at least two bids from companies qualified by or affiliated with the CDDO. The bids must be submitted and reviewed prior to the approval of the prior authorization.
- All assistive services must have prior authorization. The beneficiary or responsible party must arrange for the purchase. Work must not be initiated until approval has been obtained through prior authorization.

Note: Responsible party is defined as the beneficiary's guardian or someone appointed by the beneficiary or guardian who is not a paid provider of services for the beneficiary.

ASSISTIVE SERVICES DOCUMENTATION REQUIREMENTS

- Record-keeping responsibilities rest primarily with the Medicaid-enrolled provider.
- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
 - Copy of the receipt identifying that the service was provided
 - Name of the business or contractor
 - Identification of the service being provided
 - Date of service (MM/DD/YY)
 - Amount of purchase
 - Beneficiary's first and last name and signature (see Signature Limitations)

Note: Regardless of who signs it, the beneficiary's name must be on the form.

 - Statement of inspection by provider to insure product was purchased or installed as authorized
- Documentation must include a brief description of the service provided. Certain responsibilities may be passed to performing providers of the service.
- Documentation must be created during the time period of the billing cycle. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/12

DAY SUPPORTS

Day supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration, and participation in the community. Day supports also include the provision of prevocational services which are aimed at preparing a beneficiary for paid or unpaid employment but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Activities must be in accordance with the lifestyle choices specified in the beneficiary's PCSP. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition.

DAY SUPPORTS PROVIDER REQUIREMENTS

A provider of HCBS MRDD Day Supports must be a recognized CDDO or an affiliate, as well as licensed by the Kansas Department for Aging and Disability Services (KDADS) to provide this service.

DAY SUPPORTS LIMITATIONS

- HCBS MRDD Day Supports is available to Medicaid program beneficiaries who:
 - Are 18 years of age or older
 - *Note:* In rare circumstances, a person who is under 18 years of age with extenuating circumstances may receive services if specifically approved in writing by DBHS/CSS.
 - Are determined eligible for MRDD services
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD screening)
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Transportation costs are not covered by this service.
- Persons eligible for services through the local education authority do not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before 22 years of age, and a transition plan is developed by a transition team that includes the CDDO's representative or the CDDO's designee.
- Supported employment must be provided away from the beneficiary's place of residence.
- Supported employment activities cannot be provided until the beneficiary has applied to the local Rehabilitation Services office. The HCBS MRDD program will fund supported employment activities until the point in time when Rehabilitation Services funding for the supported employment begins. Coverage of employment-related activities under the waiver will be suspended until the case is closed by Rehabilitation Services.
- If the beneficiary is determined ineligible for vocational training through Rehabilitation Services under Section 110 of the Rehabilitation Act of 1973, then this service can be provided as a waiver service. Documentation of this determination must be maintained in the beneficiary's file.
- Case managers are responsible for ensuring that vocational rehabilitation services are NOT being duplicated for waiver beneficiaries.

8400. BENEFITS AND LIMITATIONS Updated 07/12

DAY SUPPORTS

To receive reimbursement (five of seven days a week):

- It is the desired outcome of DBHS/CSS that beneficiaries receiving Day Supports have the opportunity to receive such services consistent with their preferred lifestyle a minimum of 25 hours per week. DBHS/CSS understands each beneficiary has unique support needs, and this outcome can be met in a variety of ways.
- Beneficiaries must be out of their home a minimum of five hours per day or a total of 25 hours per week unless one of the following applies:
 - A person operates a home-based business
 - A person is unable to be out of their home due to medical necessity or significant physical limitations related to frailty which a physician has provided current, written verification for the necessity to remain in the house

Note: Current is within the past 185 days and must be reviewed at least every 185 days thereafter.

- Those eligible to receive services while they remain in the home must participate in activities consistent with their PCSPs. These activities must replicate those which would normally occur outside the home.
- For those who prefer not to receive day supports five days a week, supporting documentation consistent with this preference must be available in their PCSPs.
- To receive reimbursement for five of seven days a week, the provider must document that services were provided at least 25 hours during the community service providers' defined seven-day week. This may be accomplished through documentation indicating the person received more than five hours of services on some days and less than five hours per day on other days.
- For those receiving less than 25 hours of supports within the community service providers' defined seven-day week, time may be accumulated and then billed for the appropriate number of full and/or partial units (which may be as small as .10 unit, equal to 30 minutes). Time may not be carried over from one defined seven-day week to the next defined seven-day week.

DAY SUPPORTS DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must consist of an attendance record. Minimum components of an attendance record include:
 - Name of the service
 - Beneficiary's first and last name
 - Date of service (MM/DD/YY)
 - Check mark to indicate the beneficiary received the service as defined
 - Signature of a responsible staff person verifying the information is correct
- If the beneficiary did not receive a full day of service, then some alternate mark must be used to indicate what portion of the service was provided on that date. A key to define all coding should be present on the attendance form.
- This record must be created and maintained during the timeframe covered by the document. Creating documentation after that time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 06/11

MEDICAL ALERT

Medical alert and other monitoring systems provide support to the beneficiary having a medical need that could become critical at any time.

The following are examples of medical needs that might require this service:

- Quadriplegia
- Severe heart conditions
- Diabetes which is difficult to control
- Severe convulsive disorders
- Severe chronic obstructive pulmonary disease
- Head injury

Medical Alert providers dispense adult failure alarm systems which are small pieces of electronic equipment linked to the beneficiary's phone which can automatically dial three phone numbers when buttons on the instrument are pushed.

The first call is placed to a predetermined responder who answers the call for help. Ideally, the responder is a relative or friend who volunteers his or her services. However, it may be considered part of the case manager's duties. The second call should be to a physician, and the third to a medical emergency unit or center.

The adult failure system (e.g., medical alert) can be maintained for a 30-day period if a beneficiary is placed in a nursing home or a hospital for a short stay. This avoids the need to discontinue and reinstall the service which is both disruptive and costly to the patient.

MEDICAL ALERT LIMITATIONS

- HCBS MRDD Medical Alert rental is available to Medicaid program participants who both:
 - Meet the criteria for the ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Are determined eligible for MRDD services
- HCBS MRDD program services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.
- Rental, but **not** purchase, of this unit is covered.
- This service must be billed at a monthly rate.

MEDICAL ALERT ENROLLMENT

Home health agencies do not have to complete a separate provider enrollment application when providing this service.

Examples of qualified providers of this service include, but are not limited to, agencies, hospitals, and emergency transportation service companies.

8400. BENEFITS AND LIMITATIONS Updated 06/11

MEDICAL ALERT

MEDICAL ALERT DOCUMENT REQUIREMENTS

- Documentation, at a minimum, must include the following:
 - Service provider's name
 - Service being provided
 - Date of invoice or statement (MM/DD/YY)
 - Beneficiary's first and last name
 - Month of coverage (MM/YY)
 - Cost of service
- Documentation must be created during the timeframe of the billing cycle. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/12

OVERNIGHT RESPITE

Overnight Respite is temporary care provided to a beneficiary to provide relief for the beneficiary's family member who serves as an unpaid primary caregiver. Respite is necessary for families who provide constant care for beneficiaries. It allows family members to receive periods of relief for vacations, holidays, and scheduled periods of time off.

OVERNIGHT RESPITE LIMITATIONS

- HCBS MRDD Overnight Respite care services are available to Medicaid beneficiaries who:
 - Are five years of age or older
 - Are mentally retarded or otherwise developmentally disabled
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
 - Have a family member who serves as the primary caregiver who is not paid to provide any HCBS MRDD program service for the beneficiary
- HCBS MRDD Overnight Respite services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- HCBS MRDD services cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Room and board costs are excluded in the cost of any HCBS MRDD waiver services except overnight facility-based respite.
- Overnight Respite may only be provided to beneficiaries living with a person immediately related to the beneficiary. Immediate family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any stepfamily relationships.
- Overnight Respite cannot be provided by a beneficiary's spouse or by a parent of a beneficiary who is a minor child under 18 years of age.
- Beneficiaries receiving Overnight Respite cannot also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.
- A beneficiary can receive Overnight Respite services from more than one worker, but no more than one worker can be paid for services at any given time of day. An Overnight Respite provider cannot be paid to provide services to more than one beneficiary at any given time of day.
- Overnight Respite is limited to 60 days, per beneficiary, per calendar year.
- Overnight Respite is billed on a daily rate, and the services provided must meet the beneficiary's support needs for a minimum of eight and maximum of 12 hours.
- Overnight Respite care will be provided in the following locations and allow for staff to sleep:
 - Beneficiary's home or place of residence
 - Licensed foster home
 - Facility approved by KDHE or KDADS which is not a private residence
 - Licensed respite care facility/home

8400. BENEFITS AND LIMITATIONS Updated 07/12

OVERNIGHT RESPITE

OVERNIGHT RESPITE PROVIDER REQUIREMENTS

- Providers of Overnight Respite must be affiliated with the CDDO for the area where they operate.
- Providers of overnight facility-based respite care for minor children must be licensed by KDADS or KDHE.
- Adult respite providers must be licensed by KDADS Disability and Behavioral Health Services.
- A self-direct option may be chosen for Overnight Respite by the beneficiary. If the beneficiary is not capable of providing self-direction, the beneficiary's guardian or someone acting on his or her behalf may choose.

OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS FOR AGENCY-DIRECTED SERVICES

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
 - Name of service being provided
 - Beneficiary's first and last name
Note: Regardless of who signs it, the beneficiary's name must be on the form.
 - Caregiver's name and signature
 - Date of service (MM/DD/YY)
 - Start time for each visit, include AM/PM or use 2400 clock hours
 - Stop time for each visit, include AM/PM or use 2400 clock hours
- Time must be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS FOR SELF-DIRECTED SERVICES

For self-directed Overnight Respite services, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

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

8400. BENEFITS AND LIMITATIONS Updated 07/12

OVERNIGHT RESPITE

OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS FOR SELF-DIRECTED SERVICES (continued)

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

- Identification of the waiver service being provided (ex. Self-Directed Overnight Respite)
- Beneficiary's name (first and last) and signature on each page of documentation (See Signature Limitations)
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of a billing cycle. For a postpayment review, reimbursement will be recouped if documentation is not complete.

Signature Limitations

For those choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Due to a beneficiary's limitations, assistance may be required. A designated signatory can be anyone who is aware of the services provided. The individual providing the service **cannot** sign the time sheet on behalf of the beneficiary.

8400. BENEFITS AND LIMITATIONS Updated 07/12

PERSONAL ASSISTANT SERVICES

Personal Assistant Services is available to beneficiaries who choose to **SELF-DIRECT** all or a portion of their services and live in one of the following types of settings:

- A setting that would otherwise be considered an adult residential setting requiring services to be provided by an entity licensed by Disability and Behavioral Health Services – Community Supports and Services (DBHS-CSS)
- A setting where the person lives with someone meeting the definition of family

Note: Family is defined as any person immediately related to the beneficiary. Immediate-related family members are a parent (including an adoptive parent), grandparent, spouse, aunt, uncle, sister, brother, first cousin, and anyone with a step-family relationship.

- A setting where a child, 5 to 21 years of age, is in the custody of KDADS but not living with someone meeting the definition of family
- A setting in which a child, 15 years of age or older, resides with a person who does not meet the definition of family and who has not been appointed the legal guardian or custodian

Personal Assistant Services means one or more personal assistants on an individualized (one-to-one) basis ensuring the health and welfare of the beneficiary during times when the beneficiary is not typically sleeping. It means supporting the beneficiary with the tasks typically done for or by himself or herself if he or she did not have a disability. Such services include assisting individuals in performing a variety of tasks promoting independence, productivity, and integration. This service provides necessary assistance for beneficiaries both in their homes and communities.

Personal Assistant Services includes assisting with the following:

- Activities of daily living (ADLs): bathing, grooming, toileting, transferring, health maintenance activities (including but not limited to extension of therapies), feeding, mobility, and exercises
- Independent activities of daily living (IADLs): shopping, housecleaning (related to the beneficiary), seasonal chores, meal preparation, laundry, and financial management
- Support services (SS): socialization and recreational activities
- Assistance in obtaining necessary medical services and reporting changes in the beneficiary's condition and needs
- Accompanying or providing transportation to accomplish any of the tasks previously listed

PERSONAL ASSISTANT SERVICES REVISED LIMITATIONS

- All Personal Assistant Services must be arranged for, and purchased under, the beneficiary's or responsible party's written authority and paid through an enrolled Financial Management Services (FMS) provider consistent with and not exceeding the beneficiary's POC. Beneficiaries are permitted to choose qualified direct support workers who have passed background checks that ensure compliance with KAR 30-63-28(f).
- Beneficiaries who were receiving agency-directed services and at some point chose to self-direct their services and then determined that they no longer wanted to self-direct their Personal Assistant Services will have the opportunity to receive their previously approved waiver services, without penalty.
- A direct support worker cannot perform any duties for the beneficiary that would otherwise be consistent with the Supported Employment definition, Sections 1.a & b.

8400. BENEFITS AND LIMITATIONS Updated 07/12

PERSONAL ASSISTANT SERVICES

PERSONAL ASSISTANT SERVICES REVISED LIMITATIONS continued

- The expectation is that waiver beneficiaries who need assistance with IADL tasks should rely on informal/natural supporters for this assistance unless there are extenuating circumstances that have been documented in the PCSP.
 - For example, the PCSP defines the role of the direct support worker as a person who is teaching the beneficiary how to perform a skill.
 - In accordance with this expectation, Personal Assistant Services should not be used for lawn care, snow removal, shopping, ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the beneficiary lives), and meal preparation (during the times when the person with whom the beneficiary lives would normally prepare the meal).
- Personal Assistant Services can be retained up to a maximum of 14 days per calendar year, at a level consistent with the approved POC. These services are retained during times when the beneficiary is an inpatient of a hospital, nursing facility, or ICF/MR and the facility is billing Medicaid, Medicare, and/or private insurance. This is provided to assist beneficiaries who self-direct their care with retaining their current direct support worker(s).
- Beneficiaries receiving Residential Supports **cannot** also receive Personal Assistant Services as an alternative for the same residential supports or any of the other family/individual supports. This does not prevent the conversion of Day Supports to Personal Assistant Services.
- Beneficiaries receiving Day Supports **cannot** also receive Personal Assistant Services as an alternative for the same day supports. This does not prevent the conversion of Residential Supports to Personal Assistant Services.
- A beneficiary can have several direct support workers providing him or her care on a variety of days at a variety of times, but a person **cannot** have more than one direct support worker providing care at any given time. The State MMIS will not make payments for multiple claims filed for the same time on the same dates of service.
- In addition, the State will not approve POCs for which it is determined that the provisions of Personal Assistant Services would be a duplication of services already approved on the POC.
- Personal Assistant Services are limited to a maximum of an average eight hours per day in any given month. The services are only for the activities described previously unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The absolute maximum allowable Personal Assistant Services is an average of twelve hours per day in any given month.

PERSONAL ASSISTANT SERVICES PROVIDER REQUIREMENTS

- As indicated in K.A.R. 30-63-10, any direct support worker providing services must be at least 16 years of age or at least 18 years of age if a sibling of the beneficiary. Personal Assistant Services being provided as a self-directed alternative to Residential Supports or Day Supports cannot be provided by the legal guardian of the beneficiary.
- Providers must be either a CDDO or an affiliate of the CDDO who also functions as an enrolled Financial Management Services provider.

8400. BENEFITS AND LIMITATIONS Updated 07/12

PERSONAL ASSISTANT SERVICES

PERSONAL ASSISTANT SERVICES PROVIDER REQUIREMENTS (continued)

- Consistent with K.A.R. 30-63-10, the beneficiary or the beneficiary's responsible party must maintain documentation showing that the individual direct support worker has received sufficient training to meet the beneficiary's needs. Written certification must be provided to the CDDO.
- Direct support workers are required to pass background checks consistent with the KDADS background check policy and comply with all regulations related to abuse, neglect, and exploitation.

PERSONAL ASSISTANT SERVICES DOCUMENTATION REQUIREMENTS

For Personal Assistant Services, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

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

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

- Identification of the waiver service being provided (such as Self-Directed Personal Assistant Services)
- Beneficiary's name (first and last) and signature on each page of documentation
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of a billing cycle. For a postpayment review, reimbursement will be recouped if documentation is not complete.

8400. BENEFITS AND LIMITATIONS Updated 07/12

RESIDENTIAL SUPPORTS

This service is provided to beneficiaries who live in a residential setting and do not live with someone meeting the definition of family. Family is defined as any person immediately related to the beneficiary of services. Immediately related family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins, and any step-family relationships. This service provides assistance, acquisition, retention, and/or improvement in skills related to activities of daily living, such as, personal grooming and cleanliness, bed making and household chores, food preparation, and the social and adaptive skills necessary to enable the beneficiary to reside in a noninstitutional setting. Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than costs for modifications or adaptations to the facility as required to assure the health and safety of beneficiaries or to meet the requirements of the applicable life safety code. Payment for Residential Supports does not include payments made, directly or indirectly, to members of the beneficiary's immediate family. Payments will not be made for routine care and supervision which is expected to be provided by immediate family members or for which payment is made by a source other than Medicaid. This service will not be offered in a setting with nine or more beds.

Residential Supports for *adults* is authorized for persons 18 years of age or older and is provided by entities licensed by DBHS/CSS.

Residential Supports for *children* is provided for children 5 through 21 years of age. This service is designed to serve children who are not in the custody of KDADS in order to avoid placement in an institution or other congregate residential setting when they cannot, for whatever reason, remain in their natural families. Residential Supports for children must occur outside the child's family home in a setting licensed by child placing agencies applying the regulations of the Kansas Department of Health and Environment (KDHE). No more than two children, unrelated by blood or marriage to the surrogate family, can be living in a residential supports setting for children. Residential Supports for children also must:

- Cooperate with case management, the school district, and any consultants in designing and implementing specialized training procedures
- Actively participate in individualized education plan (IEP) development and the public school education program
- Be located in or near the community where the child's family lives

RESIDENTIAL SUPPORTS LIMITATIONS

- HCBS MRDD Residential Supports is available to Medicaid beneficiaries who:
 - Are five years of age or older
 - Are mentally retarded or otherwise developmentally disabled
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD is available to minor children, 5 through 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- HCBS MRDD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.

KANSAS MEDICAL ASSISTANCE PROGRAM
HCBS MRDD PROVIDER MANUAL
RESIDENTIAL SUPPORTS
BENEFITS & LIMITATIONS

8400. BENEFITS AND LIMITATIONS Updated 07/12

RESIDENTIAL SUPPORTS

RESIDENTIAL SUPPORTS LIMITATIONS (continued)

- Room, board, and transportation costs are excluded in the cost of any HCBS MRDD services except overnight facility-based respite.
- Beneficiaries of Residential Supports cannot also receive Supportive Home Care, Personal Assistant Services (as an alternative to Residential Supports), Overnight Respite, or Sleep Cycle Support.
- Residential Supports cannot be provided in the beneficiary's family home. However, this service may be provided to a beneficiary in his or her own home or apartment as long as the community service provider is licensed by KDADS to provide this service.
- Residential Supports for *children* cannot be provided in a home where more than two beneficiaries funded with State or Medicaid money reside.
- Children who receive Residential Supports with a nonrelated family must be at least 5 but no older than 21 years of age (eligibility ends on the 22nd birthday).
- Residential Supports is paid on a daily rate where one unit equals one day.
- This service is billed on daily tiered rates.
- Specific to Residential Supports provided to children, no more than 20% of the aggregated tiered reimbursement for all beneficiaries can be retained by the child-placing agency to defray administrative costs.

RESIDENTIAL SUPPORTS PROVIDER REQUIREMENTS

- Providers of Residential Supports for *children* must be affiliated with the CDDO for the area where they operate and be licensed by KDHE as a child-placing agency (K.A.R. 28-4-171).
- Providers of Residential Supports for *adults* must be a CDDO or affiliate that is licensed by KDADS to provide Residential Supports.
- Residential Supports for *adults* can serve no more than eight individuals in one home.
- All providers of Residential Supports must be in compliance with K.A.R. Article 30-63-21 through 30-63-30.

RESIDENTIAL SUPPORTS DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation at a minimum must consist of an attendance record. Minimum components of an attendance record include:
 - Name of the service
 - Beneficiary's first and last name
 - Date of service (MM/DD/YY)
 - Check mark to indicate the beneficiary received the service as defined
 - Signature of a responsible staff person verifying the information is correct
- In order to bill the daily rate, the beneficiary must be present for supports to be provided. Also, it must be documented that the supports were provided and/or the provider was available to provide the necessary supports to the beneficiary, if needed.
- If the beneficiary did not receive a full day of service, then some alternate mark should be used to indicate what portion of the service was provided on that date.
- A key to define all coding should be present on the attendance form.

8400. BENEFITS AND LIMITATIONS Updated 06/11

RESIDENTIAL SUPPORTS

RESIDENTIAL SUPPORTS DOCUMENTATION REQUIREMENTS (continued)

- This record must be created and maintained during the time period covered by the document. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SLEEP CYCLE SUPPORT

The primary purpose of Sleep Cycle Support is to give overnight assistance to beneficiaries living with a person who meets the definition of family or in a setting that does not meet the definition of living with family and the person has chosen to self-direct the service. The direct support worker must be immediately available but can sleep when not needed. The duties of a Sleep Cycle Support direct support worker include:

- Calling a doctor or hospital
- Providing assistance if an emergency occurs
- Turning and repositioning the beneficiary
- Assisting with peri-care and/or toileting
- Reminding the beneficiary of nighttime medication
- Administering medication when necessary

The direct support worker does not perform any other personal care, training, or homemaker tasks.

SLEEP CYCLE SUPPORT LIMITATIONS

- HCBS MRDD Sleep Cycle Support is available to Medicaid program beneficiaries who:
 - Are five years of age or older
 - Meet the criteria for ICF/MR level of care as determined by the HCBS MRDD screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD is available to children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- Sleep Cycle Support cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Sleep Cycle Support cannot be provided by the beneficiary's spouse or by a parent of a beneficiary less than 18 years of age.
- Sleep Cycle Support cannot be provided to beneficiaries of Residential Supports.
- Sleep Cycle Support is limited to beneficiaries unable to be alone at night due to anticipated medical problems.
- The period of service for Sleep Cycle Support is a minimum of 8 hours and cannot exceed 12 hours.
- The self-direct option may be chosen for Sleep Cycle Support by the beneficiary. If the beneficiary is incapable of providing self-direction, his or her guardian, parent, or other person acting on his or her behalf may choose.
- A beneficiary can receive Sleep Cycle Support from more than one worker, but no more than one worker can be paid for services at any given time of day. A Sleep Cycle Support provider cannot be paid to provide services to more than one beneficiary at any given time of day.
- A statement of **medical necessity**, signed by a physician, must be on record.

SLEEP CYCLE PROVIDER REQUIREMENTS

Sleep Cycle Support must be provided by a CDDO or an agency affiliated with a CDDO, who may or may not be licensed by KDADS for other purposes, who is enrolled in KMAP. Sleep Cycle Support for beneficiaries choosing to self-direct service must be provided by an affiliate of the CDDO who also functions as an enrolled FMS provider.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SLEEP CYCLE SUPPORT

AGENCY-DIRECTED SLEEP CYCLE SUPPORT DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
 - Service being provided
 - Beneficiary's first and last name and signature (see Signature Limitations)
Note: Regardless of who signs it, the beneficiary's name must be on the form.
 - Caregiver's name and signature
 - Date of service (MM/DD/YY)
 - Start time for each visit, include AM/PM or use 2400 clock hours
 - Stop time for each visit, include AM/PM or use 2400 clock hours
 - Brief description of the duties performed including any changes in the beneficiary's status
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.
- Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.

Signature Limitations

When choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided knowing the beneficiary may have limitations. A designated signatory can be anyone aware of the services provided. The individual providing the service **cannot** sign the time sheet on behalf of the beneficiary.

Each time sheet must contain the signature of the beneficiary or designated signatory verifying the services received and the time recorded. Approved signing options include:

- Beneficiary's signature
- Beneficiary making a distinct mark representing his or her signature
- Beneficiary using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider must establish, document, and monitor a plan based on the situation.

If a beneficiary refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the attendant's time may not be paid or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are a matter for the billing provider to address.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SLEEP CYCLE SUPPORT

SELF-DIRECTED OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS

For Self-Directed Overnight Respite Services documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, KS AuthentiCare. Electronic visit verification documentation must, at a minimum, include the following:

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

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

- Identification of the waiver service being provided (such as Self-Directed Overnight Respite)
- Beneficiary's name (first and last) and signature on each page of documentation (see Signature Limitations)
- Direct support worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

8400. BENEFITS AND LIMITATIONS Updated 07/12

SPECIALIZED MEDICAL CARE

This service provides long-term nursing support for medically fragile and technology dependent beneficiaries. The required level of care must provide medical support for a beneficiary needing ongoing, daily care that would otherwise require the beneficiary to be in a hospital. The intensive medical needs of the beneficiary must be met to ensure the person can live outside of a hospital or ICF/MR. For the purpose of this waiver, a provider of Specialized Medical Care must be a registered nurse (RN), a licensed practical nurse (LPN) under the supervision of an RN, or another entity designated by Kansas Department of Children and Families, Department of Disability and Behavioral Health Services (DCF-DBHS). Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of beneficiaries within the scope of the State's Nurse Practice Act.

- The service may be provided in all customary and usual community locations including where the beneficiary resides and socializes.
- It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the beneficiaries.
- Specialized Medical Care does not duplicate any other Medicaid state plan service or other services available to the beneficiary at no cost.
- Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.

SPECIALIZED MEDICAL CARE LIMITATIONS

- HCBS MRDD Specialized Medical Care services are available to Medicaid beneficiaries who:
 - Are five years of age or older
 - Are mentally retarded or otherwise developmentally disabled
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD is available to minor children, 5 through 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- HCBS MRDD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Room, board, and transportation costs are excluded in the cost of any HCBS MRDD services except overnight facility-based respite.
- Beneficiaries of Specialized Medical Care cannot also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.
- Specialized medical care services may not be provided by a beneficiary's spouse or by a parent of a beneficiary who is a minor child under 18 years of age.
- Specialized medical care services are limited to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month. One unit is equal to 15 minutes.
- A beneficiary can receive specialized medical care services from more than one worker, but no more than one worker can be paid for services at any given time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one beneficiary at any given time of day.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SPECIALIZED MEDICAL CARE

Signature Limitations

When choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided knowing the beneficiary may have limitations. A designated signatory can be anyone aware of the services provided. However, the individual providing the services **cannot** sign the time sheet on behalf of the beneficiary.

Each time sheet must contain the signature of the beneficiary or designated signatory verifying the services received and the time recorded. Approved signing options include:

- Beneficiary's signature
- Beneficiary making a distinct mark representing his or her signature
- Beneficiary using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider must establish, document, and monitor a plan based on the situation.

If a beneficiary refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the attendant's time may not be paid or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are the responsibility of the billing provider.

SPECIALIZED MEDICAL CARE PROVIDER REQUIREMENTS

- Providers of Specialized Medical Care are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a home health agency licensed by KDHE or other entities determined eligible by the DCF-DBHS Community Support Services (CSS). Other entities determined eligible, prior to becoming an approved provider, must submit a letter from the HCBS MRDD program manager stating that DCF-DBHS/CSS has determined the entity is a qualified provider of Specialized Medical Care.
- Providers of Specialized Medical Care must be affiliated with the CDDO for the area(s) where they operate.
- All providers of Specialized Medical Care must be in compliance with K.A.R. Article 30-63-21 through 30-63-30.

SPECIALIZED MEDICAL CARE DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed. Documentation at a minimum must include the following:
 - Name of the service
 - Beneficiary's first and last name and signature (see Signature Limitations)
Note: Regardless of who signs it, the beneficiary's name must be on the form.
 - Caregiver's name and signature (for each entry)
 - Date of service (MM/DD/YY) for each entry
 - Start time for each visit, include AM/PM or use 2400 clock hours
 - End time for each visit, include AM/PM or use 2400 clock hours
 - A brief description of duties performed for each entry

8400. BENEFITS AND LIMITATIONS Updated 06/11

SPECIALIZED MEDICAL CARE

SPECIALIZED MEDICAL CARE DOCUMENTATION REQUIREMENTS (continued)

- If coding is used, a key to define all coding must be included.
- This record must be created and maintained during the time period covered by the document. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SUPPORTED EMPLOYMENT

Supported Employment is competitive work in an integrated setting with on-going support services for beneficiaries who have MRDD. Competitive work is defined as compensated work in accordance with the Fair Labor Standards Act. An integrated work setting is a job site that is similar to that of the general work force. Such work is supported by any activity needed to sustain paid employment by persons with disabilities.

The following supported employment activities are designed to assist beneficiaries in acquiring and maintaining employment.

- Individualized assessment
- Individualized job development and placement services to create an appropriate job match for the beneficiary and the employer
- On-the-job training in skills required to perform the necessary functions of the job
- Ongoing monitoring of the beneficiary's performance on the job
- Ongoing support services necessary to ensure job retention as identified in the PCSP
- Training in related skills essential to secure and retain employment

SUPPORTED EMPLOYMENT LIMITATIONS

- HCBS MRDD Supported Employment is available to Medicaid beneficiaries who:
 - Are 18 years of age or older
 - Are determined eligible for MRDD services
 - Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MRDD) screening
 - Choose to receive HCBS MRDD rather than ICF/MR services
- HCBS MRDD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.
- Transportation costs are not covered by this service.
- Beneficiaries 18 to 21 years of age who are receiving a similar service supported by an Individual Education Plan cannot access this service.
- Supported Employment must be provided away from the beneficiary's place of residence.
- Supported employment services must not be provided until the beneficiary has applied to the local Rehabilitation Services office. The HCBS MRDD waiver will fund supported employment activities until Rehabilitation Service's funding for the supported employment begins. Coverage under the waiver will be suspended until the case is closed by Rehabilitation Services.
- If the beneficiary is determined ineligible for vocational training through Rehabilitation Services under Section 110 of the Rehabilitation Act of 1973, then this service can be provided as a waiver service. Documentation of this determination must be maintained in the beneficiary's file.
- Case managers are responsible for ensuring that vocational rehabilitation services are NOT being duplicated for waiver beneficiaries.

SUPPORTED EMPLOYMENT PROVIDER REQUIREMENTS

A provider of MRDD Supported Employment must be a recognized CDDO or an affiliate, as well as licensed by KDADS to provide this service.

8400. BENEFITS AND LIMITATIONS Updated 09/11

SUPPORTED EMPLOYMENT

SUPPORTED EMPLOYMENT DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
 - Name of the service
 - Beneficiary's first and last name
 - Date of the service (MM/DD/YY)
 - Check mark to indicate the beneficiary received the service as defined
 - Signature of a responsible staff person verifying the information is correct
- Documentation must be created during the timeframe of the billing cycle. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SUPPORTIVE HOME CARE

Supportive Home Care (SHC) services are provided by an agency (not self-directed by the person receiving services) to assist a person living with someone meeting the definition of family **OR** in one of the following settings:

- A setting where a child, 5 to 21 years of age, is in the custody of KDADS but not living with someone meeting the definition of family
- A setting in which a child, 15 years of age or older, resides with a person who does not meet the definition of family and who has not been appointed the legal guardian or custodian

Note: Family is defined as any person immediately related to the beneficiary. Immediate-related family members are a parent (including an adoptive parent), grandparent, spouse, aunt, uncle, sister, brother, first cousin, and anyone with a step-family relationship.

These are individualized (one-to-one) services for beneficiaries that provide direct assistance with:

- Daily living and personal adjustment
- Attendant care
- Assistance with medications that are ordinarily self-administered
- Accessing medical care
- Supervision
- Reporting changes in the beneficiary's condition and needs
- Extension of therapy services
- Ambulation and exercise
- Household services essential to health care at home or performed in conjunction with assistance in daily living (such as shopping, preparing and cleaning up meals, bathing, using appliances, dressing, feeding, making the bed, doing laundry, and cleaning the bathroom and kitchen)
- Household maintenance related to the beneficiary

Note: The SHC worker can accompany or transport the beneficiary to accomplish any of the tasks listed above or provide supervision or support for community activities.

SUPPORTIVE HOME CARE REVISED LIMITATIONS

- SHC services cannot be provided by a beneficiary's spouse or by a parent of a beneficiary who is a minor child under 18 years of age.
- SHC beneficiaries cannot also receive Residential Supports.
- SHC services cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the beneficiary's IEP. In order to verify that SHC services are not used as a substitute, an SHC Services Schedule (MR-10) must clearly define the division of educational services and SHC services. Educational services must be equal to or greater than the seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimum number of hours required for kindergarten students is seven hours per day for those eligible for full-day kindergarten services and three-and-a-half hours per day for those eligible for half-day kindergarten.

8400. BENEFITS AND LIMITATIONS Updated 09/11

SUPPORTIVE HOME CARE

SUPPORTIVE HOME CARE REVISED LIMITATIONS (continued)

- SHC services are limited to a maximum of an average eight hours per day in any given month. The services are only for the activities described previously unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The absolute maximum allowable Supportive Home Care is an average of twelve hours per day in any given month.
- A beneficiary can receive SHC services from more than one worker, but no more than one worker can be paid for services at any given time of day.
- SHC services cannot be provided to a beneficiary who is an inpatient of a hospital, nursing facility, or ICF/MR when the inpatient facility is billing Medicaid, Medicare, and/or private insurance.

It is the expectation that beneficiaries who need assistance with IADL tasks, and who live with someone meeting the definition of family who is capable of performing the IADL tasks, should rely on these informal/natural supporters for assistance unless there are extenuating or specific circumstances that have been documented in the PCSP. For example, the PCSP defines the role of the SHC provider as a person who is teaching the beneficiary how to perform a certain skill. In accordance with this expectation, SHC services should not be used for the following:

- Lawn care
- Snow removal
- Shopping
- Ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the beneficiary lives)
- Meal preparation during the times when the person with whom the beneficiary lives would normally prepare a meal

SHC retainer services can be billed up to a maximum of 14 days per calendar year, at a level consistent with the approved POC. These services are provided during the period of time when the beneficiary is an inpatient of a hospital, nursing facility, or ICF/MR when the facility is billing Medicaid, Medicare, and/or private insurance. They are provided to assist beneficiaries who self-direct their care with retaining their current care provider(s).

SHC providers may be reimbursed for up to 20 hours per calendar year to allow for payment to SHC attendants to attend training opportunities which will benefit the attendant in the provision of services to the beneficiary.

A description of expectations for SHC workers must be maintained and available for review. The descriptions are subject to audit.

If services are provided to children accessing services from the Local Education Authority, a separate description of expectations for SHC workers (one for when in school and one for when not in school) may be appropriate and must also be available for review. The services provided in this waiver will in no way supplant those available through a child's IEP or IFSP or services available through Section 504 for the Rehabilitative Services Act of 1973. The descriptions are subject to audit.

As part of the POC development process, the needs of all persons receiving SHC services are limited to those times not covered by Day Supports.

**KANSAS MEDICAL ASSISTANCE PROGRAM
HCBS MRDD PROVIDER MANUAL
SUPPORTIVE HOME CARE
BENEFITS & LIMITATIONS**

8400. BENEFITS AND LIMITATIONS Updated 09/11

SUPPORTIVE HOME CARE

SUPPORTIVE HOME CARE PROVIDER REQUIREMENTS

SHC providers must be affiliated with the CDDO for the area where they operate. As indicated in K.A.R. 30-63-10, any individual providing services must be at least 16 years of age or at least 18 years of age if a sibling of the beneficiary. All individuals providing services must receive at least 15 hours of prescribed training or the person directing and controlling the services must provide written certification to the CDDO that sufficient training to meet the beneficiary's needs has been provided.

The beneficiary may choose the self-direct option for SHC. If the person is incapable of providing self-direction, the beneficiary's guardian, family member, or person acting on his or her behalf may choose.

Any entity providing Attendant Care, Personal Service, or serving as a payroll agent for attendant/personal care services must maintain a current listing of the name, address, and telephone number of all providers rendering these services.

Any entity required to maintain a current list of the name, address, and telephone number of attendant/personal care persons will, upon request, make such information available to federal and state agencies, law enforcement, the attorney general's office, and legislative post audit. If there is a dispute between the provider and a requesting entity on whether the list should be released, the state agency responsible for the program will make the final decision.

SUPPORTIVE HOME CARE DOCUMENTATION REQUIREMENTS

- Recordkeeping responsibilities rest primarily with the Medicaid-enrolled provider.
- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
 - Beneficiary's first and last name and signature (see Signature Limitations)
Note: Regardless of who signs it, the beneficiary's name must be on the form.
 - Caregiver's name and signature
 - Complete date of service (MM/DD/YY)
 - Start time for each visit, include AM/PM or use 2400 clock hours
 - Stop time for each visit, include AM/PM or use 2400 clock hours
 - Brief description of duties performed
- Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle.
- Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 06/11

SUPPORTIVE HOME CARE

Signature Limitations

When choosing the self-directed option, the expectation is that the beneficiary provides oversight and accountability for those providing services. Signature options are provided knowing the beneficiary may have limitations. A designated signatory can be anyone aware of the services provided. However, the individual providing the services **cannot** sign the time sheet on behalf of the beneficiary.

Each time sheet must contain the signature of the beneficiary or designated signatory verifying the services received and the time recorded. Approved signing options include:

- Beneficiary's signature
- Beneficiary making a distinct mark representing his or signature
- Beneficiary using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider must establish, document, and monitor a plan based on the situation.

If a beneficiary refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the attendant's time may not be paid or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are the responsibility of the billing provider.

8400. BENEFITS AND LIMITATIONS Updated 09/11

WELLNESS MONITORING

Wellness Monitoring requires an RN to evaluate the beneficiary's level of wellness. The RN determines if the beneficiary is properly using medical health services as recommended by the physician and if the beneficiary is maintaining a stable health status in his or her place of residence without frequent skilled nursing intervention. Wellness Monitoring reduces the need for routine check-ups in a costly medical care facility.

Wellness Monitoring includes checking and/or monitoring the following:

- Orientation to surroundings
- Skin characteristics
- Edema
- Personal hygiene
- Blood pressure
- Respiration
- Pulse
- Adjustments to medications

WELLNESS MONITORING LIMITATIONS

- A beneficiary eligible for Wellness Monitoring lives in a noninstitutional setting.
- The beneficiary is able to maintain independence with Wellness Monitoring visits no more than every 60 days.
- Direct medical intervention is obtained through the appropriate medical provider and is NOT funded by this program.
- Wellness Monitoring must be provided by a licensed RN in private employment or employed by a home health agency, local health department, CDDO, or affiliate.
- The RN who provides Wellness Monitoring may also provide nursing care and supervise medical attendants.
- Wellness Monitoring is not covered for HCBS MRDD beneficiaries when provided within the same 60-day period as skilled nursing services provided by a home health agency.
- Only one visit by an RN, per 60 days, is covered.

Note: Consideration will be made when documentation submitted with the claim indicates the medical need. This limitation will be monitored postpay.

WELLNESS MONITORING ENROLLMENT

Private RNs must attach a copy of their nursing license to the provider enrollment packets.

WELLNESS MONITORING DOCUMENTATION REQUIREMENTS

- The Wellness Monitoring RN must provide the case manager with a brief written summary following each visit, indicating how the beneficiary is doing under the services currently provided. With the beneficiary's written consent, this may also be forwarded to the primary care physician as appropriate.
- Written documentation is required for services provided and billed to KMAP.

8400. BENEFITS AND LIMITATIONS Updated 06/11

WELLNESS MONITORING

WELLNESS MONITORING DOCUMENTATION REQUIREMENTS (continued)

- Documentation, at a minimum, must include the following:
 - Beneficiary's first and last name
 - Nurse's name and signature with credentials
 - Date of service (MM/DD/YY)
 - Clinical measurements
 - Review of systems
 - Additional observations, interventions, teaching issues or other matters, as needed
- Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

DEFINITIONS Updated 12/11

MRDD screening – an assessment of the adaptive needs, maladaptive behaviors, and health needs of the beneficiaries who are mentally retarded or developmentally disabled to determine their eligibility for ICF/MR level of care.

Community developmental disability organization (CDDO) - a local agency, specified by county government, which directly receives county mill funds and state aid and either directly and/or through a network of affiliates provides community-based services to beneficiaries who are mentally retarded or developmentally disabled, and is formally recognized by KDADS.

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

Plan of care (POC) - a document completed following the determination of ICF/MR eligibility, after the beneficiary elects HCBS MRDD instead of ICF/MR services. This document, subject to the approval of the HCBS MRDD program manager, must include:

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

**Expected Service Outcomes for Individuals or Agencies Providing HCBS MRDD Services
Updated 06/11**

1. Services are provided according to the POC, in a quality manner, and as authorized on the Notice of Action.
2. Provision of services is coordinated in a cost-effective and quality manner.
3. Beneficiary's independence and health are maintained, when possible, in a safe and dignified manner.
4. Beneficiary's concerns and needs, such as changes in health status, are communicated to the case manager or independent living counselor within 48 hours. This includes any ongoing reporting as required by the Medicaid program.
5. Failure or inability to provide services as scheduled in accordance with the POC are reported immediately, but not to exceed 48 hours, to the case manager or the independent living counselor.