Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Provider Manual

HCBS
Traumatic Brain Injury

Updated 07/2012

PART II
HCBS TBI PROVIDER MANUAL

FORMS All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp under Pricing and Limitations.

INTRODUCTION TO THE HCBS TBI WAIVER PROGRAM

Updated 07/12

The Home and Community Based Services (HCBS) Traumatic Brain Injury (TBI) waiver is designed to meet the needs of beneficiaries who have sustained a traumatically acquired external nondegenerative, structural brain injury resulting in residual deficits and disability. The HCBS waivers are designed to prevent institutionalization of beneficiaries. The variety of services listed 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 HCBS programs. Services include:

- Assistive Services
- Financial Management Services
  Note: Refer to the *HCBS Financial Management Services Provider Manual* for criteria and information.
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Services Agency-Directed
- Personal Services Self-Directed
- Rehabilitation therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy, and Occupational Therapy
- Sleep Cycle Support
- Transitional Living Skills

Medicaid waiver services are limited to those services which cannot be procured from other formal or informal resources. Medicaid waiver funds are to be used as the funding source of last resort.

All HCBS TBI 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. The limitations for HCBS TBI Assistive Services in this manual are different than the limitations for this MFP service. Please refer to the *Money Follows the Person Provider Manual* for criteria and information.

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

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

INTRODUCTION TO THE HCBS TBI WAIVER PROGRAM

Updated 07/12

Documentation Using "Notes" in KS AuthentiCare

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

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

HIPAA Compliance

As a participant in the Kansas Medical Assistance Program (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. HCBS TBI BILLING INSTRUCTIONS Updated 07/11

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

7010. HCBS TBI SPECIFIC BILLING INFORMATION Updated 09/11

ASSISTIVE SERVICES
Enter procedure code **S5165** in field 24D of the CMS-1500.
One unit equals one purchase.

BEHAVIOR THERAPY
Enter procedure code **H0004** in field 24D of the CMS-1500.
One unit equals 15 minutes.

COGNITIVE REHABILITATION
Enter procedure code **97532** in field 24D of the CMS-1500.
One unit equals 15 minutes.

HOME-DELIVERED MEALS
Enter diagnosis code **780.99** in field 21 of the CMS-1500.
Enter procedure code **S5170** (includes preparation per meal) in field 24D of the CMS-1500.
One unit equals one meal, with a maximum of two meals per calendar date.

MEDICATION REMINDER SERVICES
Medication Reminder (call/alarm) – Enter procedure code **S5185** in field 24D of the CMS-1500.
One unit equals one month.

Medication Reminder/Dispenser Installation – Enter procedure code **T1505** in field 24D of the CMS-1500.
One unit equals one installation, limited to one installation per calendar year.

Medication Reminder/Dispenser – Enter procedure code **T1505UB** in field 24D of the CMS-1500.
One unit equals one calendar month.

OCCUPATIONAL THERAPY
Enter procedure code **G0152** in field 24D of the CMS-1500.
One unit equals 15 minutes.

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION
Rental of Personal Emergency Response System – Enter procedure code **S5161** in field 24D of the CMS-1500.
One unit equals one month.

Installation of Personal Emergency Response System – Enter procedure code **S5160** in field 24D of the CMS-1500.
Installation is covered up to twice per calendar year.

7010. HCBS TBI SPECIFIC BILLING INFORMATION Updated 07/12

PERSONAL SERVICES
Personal Services Agency-Directed – Enter procedure code **S5125U9** in field 24D of the CMS-1500.
One unit equals 15 minutes.

Personal Services Self-Directed – Enter procedure code **S5125UB** in field 24D of the CMS-1500.
One unit equals 15 minutes.

PHYSICAL THERAPY
Enter procedure code **G0151** in field 24D of the CMS-1500.
One unit equals 15 minutes.

SLEEP CYCLE SUPPORT
Enter procedure code **T2025** in field 24D of the CMS-1500.
One unit equals 6 to 12 hours in any given 24-hour time period.

SPEECH/LANGUAGE THERAPY
Enter procedure code **G0153** in field 24D of the CMS-1500.
One unit equals 15 minutes.

TRANSITIONAL LIVING SKILLS
Enter procedure code **H2014** in field 24D of the CMS-1500.
One unit equals 15 minutes.

Note: For billing purposes, the system POC is authorized on a monthly basis. However, the total hours for a beneficiary cannot exceed the daily or weekly approved amounts as specified in the Attendant Care Worksheet, the written POC, and/or the Notice of Action.

Client Obligation
If a targeted case manager has assigned a client obligation to a particular provider and informed this provider that they are to collect this portion of the cost of service from the client, the provider will 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.

7010. HCBS TBI SPECIFIC BILLING INFORMATION Updated 09/11

Overlapping Dates of Service
The dates of service on the claim must match the dates approved on the POC and cannot overlap.
Example

An electronic POC has two detail lines items: the first line ends on the 15th of the month and the second line begins on the 16th with an increase of units.

A claim with a line item for services dated the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC for one line on a claim.

For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month will be accepted by the system and not deny because of a conflict in the dates of service.

Services for multiple months should be separated out, and each month submitted on a separate claim.

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

- HCBS services provided the date of admission, if provided prior to the beneficiary being admitted
- HCBS services provided the date of discharge, if provided following the beneficiary's discharge
- Targeted Case Management (not a HCBS Plan of Care service)
- Personal Emergency Response Systems

Signature Limitations
In all situations, the expectation is that the beneficiary provides oversight and accountability for people providing services for him or her. Signature options are provided in recognition that a beneficiary's limitations make it necessary that he or she be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided. 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 that the beneficiary received the services and that the time recorded on the time sheet is accurate. The approved signing options include one of the following:

- 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 establishes, documents, and monitors a plan based on the first three concepts above.

Beneficiaries who refuse to sign accurate time sheets without a legitimate reason should be advised that the attendant's time may not be paid or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned time sheets are a matter for the billing provider to address with the targeted case manager.

7010. HCBS TBI SPECIFIC BILLING INFORMATION Updated 09/11

Reimbursement for all HCBS TBI waiver services is limited to the beneficiary's assessed level of service need and based on the POC. Services must be reimbursed within the approved reimbursement range established by the State.

8400. BENEFITS AND LIMITATIONS Updated 09/11

HCBS for persons with a traumatically acquired brain injury are designed to prevent beneficiaries from needing to enter or remain in a Traumatic Brain Injury Rehabilitation Facility (TBIRF).

HCBS TBI services are available to individuals who are Medicaid-eligible and meet the criteria for institutionalization. The eligible beneficiary must meet the following qualifications:

- Be a Kansas resident upon receiving services and for the duration of services.
- Have been diagnosed with an externally caused, traumatically acquired, nondegenerative, structural brain injury resulting in total or partial functional disability and/or psychosocial impairment. Examples of situations where the brain injury may have occurred include:
    - Blow to the head
    - Motor vehicular accident
    - Fall to the ground
    - Physical abuse
    - Violent shaking of the head
- Be at least 16 years of age but less than 65 years of age to receive HCBS TBI waiver services. However, if a beneficiary receiving waiver services reaches age 65 and is still showing progress in his or her rehabilitation, special consideration may be given by the TBI program manager for the beneficiary to remain on the waiver past his or her 65th birthday until a time when he or she no longer significantly benefits from Transitional Living Skills and/or rehabilitation therapies. If the beneficiary will be age 16 by the time services are due to begin, the assessment may be completed prior to age 16. If a beneficiary is 64 years of age at the time of the assessment, they must begin services before the age of 65 to be eligible.
- Shows the capacity to make progress in rehabilitation and independent living skills.
- May require supervision for safety.

Rehabilitation services under the ***Kansas State Plan for Medicaid*** funding are not covered after the sixth month following the date of the first treatment following a physical debilitation resulting from acute physical trauma. Since many patients with brain injury continue to require these services well beyond the seventh month post-injury, and these therapies are necessary to maintain skills learned, they are included in the waiver.

Providers of HCBS TBI waiver services are exempt from billing Medicare for services provided to TBI waiver recipients if the services are not covered by Medicare or the beneficiary does not meet Medicare's definition of homebound services. Providers should add modifier GY to the base procedure code on the CMS-1500/837P claim form. The following codes can be used with the GY modifier: G0151, G0152, G0153, H0004, 97532, H2014, S5126 UC, and T2025.

8400. BENEFITS AND LIMITATIONS Updated 07/12

ASSISTIVE SERVICES

Assistive Services is services which meet a beneficiary's assessed need by modifying or improving a beneficiary's home and through provision of adaptive equipment. Cost-effectiveness should be considered along with other factors, including quality of life and level of independence, when including Assistive Services in a POC.

Purchase or rental of new or used tangible equipment or hardware under the definition of this service is limited to those items not covered through regular Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation or Educational System). This service will be used only as the funding source of last resort. Use of Assistive Services funds requires prior authorization from the TBI program manager or other designated Kansas Department for Aging and Disability Services (KDADS) ~~SRS~~ staff.

Assistive Services can include:

- Ramps
- Lifts
- Modifications to bathrooms and kitchens specifically related to accessibility
- Specialized safety adaptations
- Assistive technology that improves mobility or communication
- Shower chairs
- Commodes/walkers

Environmental modifications can only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years and will give first-rent priority to tenants with physical disabilities.

ASSISTIVE SERVICES LIMITATIONS

Reimbursement for this service is one unit equals one purchase. Purchase is limited to a maximum lifetime expenditure of $7,500 per beneficiary across waivers. If a beneficiary is being served by the TBI waiver and assistive services greater than $7,500 are needed, a request may be made to the TBI program manager and a determination as to override the limit will be made.

Assistive Services is available, with prior authorization from the TBI program manager, to HCBS TBI waiver beneficiaries for situations defined as "critical." Critical situations are defined as and limited to the following:

- A beneficiary is returning to the community from an institutional setting such as a nursing facility, TBI rehabilitation facility, or other medical facility. The assistive service must be critical to the beneficiary's ability to return to and remain in the community and must be a necessary expenditure within the first three months of the beneficiary's return to the community.

8400. BENEFITS AND LIMITATIONS Updated 09/11

ASSISTIVE SERVICES

ASSISTIVE SERVICES LIMITATIONS (continued)

- A TBI waiver beneficiary is in a situation where there is one of the following:
    - Confirmation by Adult Protective Services that the beneficiary is a recent victim of abuse, neglect, or exploitation
    - Confirmation by Children and Family Services that the beneficiary is a recent victim of abuse or neglect
    - Documentation showing that the beneficiary is a recent victim of domestic violence

  Note: In each case, the assistive service must be critical to the remediation of the beneficiary's abuse, neglect, exploitation, or domestic violence situation; must be a necessary expenditure within three months from the related situation; and must be necessary for the beneficiary to remain in the community.

Planning for the use of any assistive service must occur prior to a beneficiary's return to the community or other change in living status, when applicable. In all cases, the targeted case manager must provide documentation that demonstrates how the assistive service is necessary to remediate the previously described situations.

In accordance with statewide policy and guidelines, all TBI waiver beneficiaries are to be held to the same critical situation criteria when requesting Assistive Services through the TBI waiver.

ASSISTIVE SERVICES PROVIDER REQUIREMENTS

Providers of this service include contractors or durable medical equipment (DME) providers. Contractors must be licensed according to the local and county codes where they work. Providers of DME must meet the standards set in KAR 30-5-108. All providers must maintain all standards, certifications, and licenses required for the specific professional field through which the service is provided. All providers must enroll with the State's fiscal agent. However, individually qualified, nonenrolled providers can enter into an agreement with an agency enrolled to provide Assistive Services.

Assistive Services are arranged by the targeted case manager with the beneficiary's written authorization of the purchase. Beneficiaries have complete access to choose any qualified provider.

ASSISTIVE SERVICES DOCUMENTATION REQUIREMENTS

Documentation at a minimum must include the following:

- A copy of an invoice or receipt identifying that the service was provided. At a minimum, the receipt must include:
    - Name of business or contractor
    - Technology/service being provided
    - Date of service (month/day/year)
    - Amount of purchase
    - Beneficiary's first and last **printed** name and signature
- Statement of inspection by provider to ensure product was purchased/installed as authorized

Documentation must be completed at the time of purchase. Generating documentation after-the-fact 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

ASSISTIVE SERVICES

ASSISTIVE SERVICES PLAN OF CARE

Assistive Services must be approved by the TBI program manager or other designated KDADS ~~SRS~~ staff. The request should be submitted in writing by the targeted case manager and should include the service being requested, the cost of the service, and reason for the request. Supporting documentation such as a catalog price or estimate from a DME provider should also be provided.

8400. BENEFITS AND LIMITATIONS Updated 09/11

BEHAVIOR THERAPY

In general, Behavior Therapy applies to the application of findings from behavioral science research to help individuals change in ways that they would like to change. These research-based strategies are used to help increase the quality of life of the individual with TBI and decrease problem, self-destructive behavior, such as aggression, property destruction, self-injury, poor anger management, and other behaviors that can interfere with an individual's ability to adapt to and live successfully in the community. Behavior Therapy can involve looking at the individual's early life experiences, long-time internal psychological or emotional conflicts, and/or the individual's personality structure. Generally, however, Behavior Therapy emphasizes the individual's current environment. It focuses on making positive changes in that environment while improving the individual's self-control using procedures to expand the person's skills, abilities, and level of independence.

BEHAVIOR THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per beneficiary, per calendar year, for any combination of the following HCBS TBI therapies: behavior, cognitive, occupational, physical, and speech/language.

Behavior Therapy is to be provided according to the beneficiary's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the beneficiary continues to make progress in his or her rehabilitation.

BEHAVIOR THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Beneficiaries' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Beneficiaries' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 09/11

BEHAVIOR THERAPY

BEHAVIOR THERAPY PROVIDER REQUIREMENTS

Behavior Therapy must be provided by individuals who are either:

- Licensed by the Kansas Behavioral Sciences Regulatory Board
  OR
- Certified in Special Education by the Kansas State Department of Education

Other qualifications include:

- Master's degree in a behavioral science field, such as psychology or social work
  OR
- Master's degree in Special Education
  AND
- 40 hours of training in TBI
  OR
- One year of experience working with individuals with TBI

Behavior Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

8400. BENEFITS AND LIMITATIONS Updated 09/11

COGNITIVE REHABILITATION

Cognitive Rehabilitation is a treatment process in which a person works to alleviate deficits in thinking. In cases of persons with TBI, these deficits can include poor attention and concentration, memory loss, difficulty with problem solving, and dysfunctional thoughts and beliefs that can contribute to maladaptive behavior and emotional responses. Through Cognitive Rehabilitation, the individual utilizes methods that aim to help make the most of existing cognitive functioning despite the difficulties they are experiencing through various methods, including guided practice on tasks that reflect particular cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for individuals receiving Cognitive Rehabilitation is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community.

COGNITIVE REHABILITATION LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per beneficiary, per calendar year, for any combination of the following HCBS TBI therapies: behavior, cognitive, occupational, physical, and speech/language.

Cognitive Rehabilitation is to be provided according to the beneficiary's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the beneficiary continues to make progress in his or her rehabilitation.

COGNITIVE REHABILITATION DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Beneficiaries' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Beneficiaries' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 09/11

COGNITIVE REHABILITATION

COGNITIVE REHABILITATION PROVIDER REQUIREMENTS

Cognitive Rehabilitation must be provided by individuals who are either:

- Licensed by the Kansas Behavioral Sciences Regulatory Board
  OR
- Certified in Special Education by the Kansas State Department of Education

Other qualifications include:

- Master's degree in a behavioral science field, such as psychology or social work
  OR
- Master's degree in Special Education
  AND
- 40 hours of training in TBI
  OR
- One year of experience working with individuals with TBI

Cognitive Rehabilitation can be provided by an individual under the supervision of the enrolled, qualified provider.

8400. BENEFITS AND LIMITATIONS Updated 07/12

HOME-DELIVERED MEALS

Home-Delivered Meals provides a beneficiary with one or two meals per calendar date. Each meal must contain at least one-third of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to the beneficiary's home. Beneficiaries eligible for this service have been determined functionally in need of Home-Delivered Meals as indicated by the Uniform Assessment Instrument/Long Term Care Threshold score. Meal preparation provided by HCBS TBI Personal Services providers may be authorized in the beneficiary's Plan of Care for those meals not provided under Home-Delivered Meals.

HOME-DELIVERED MEALS LIMITATIONS

- Providers of Home-Delivered Meals must have on staff or contract with a certified dietician to ensure compliance with KDADS ~~Kansas Department on Aging (KDOA)~~ nutrition requirements for programs under the Older Americans Act.
- This service is limited to beneficiaries who require extensive routine physical support for meal preparation as supported by the beneficiary's Uniform Assessment Instrument/Long Term Care Threshold Score for meal preparation.
- This service may **NOT** be maintained when a beneficiary is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is not to be duplicative of the home-delivered meal service provided through the Older Americans Act, subject to the beneficiary meeting related age and other eligibility requirements, nor of meal preparation provided by attendants through Personal Services.
- This service is available in the beneficiary's home.
- No more than two home-delivered meals will be authorized per beneficiary for any given calendar date.
- This service must be authorized in the beneficiary's POC.

HOME-DELIVERED MEALS DOCUMENTATION

Proof of meal delivery is required in order to verify that the beneficiary received the meal(s). Home-Delivered Meals providers are required to maintain proof of delivery and have related documentation available upon request.

If providers use direct delivery to the beneficiary, proof of delivery documentation must include the following information:

- Service provider's name
- Description of the service provided
- Date of service (month/day/year)
- Beneficiary's name
- Cost of the service

8400. BENEFITS AND LIMITATIONS Updated 07/12

HOME-DELIVERED MEALS

HOME-DELIVERED MEALS DOCUMENTATION (continued)

If the Home-Delivered Meals provider uses a shipping service or mail order, proof of delivery could include the service's tracking document and the provider's own shipping invoice or summary report. If possible, the provider's records should also include the delivery service's ID number for the item sent to the beneficiary. The shipping service's tracking document should reference each individual delivery item, the delivery address, the corresponding ID number given by the shipping service, and the date delivered, if possible.

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory or reimbursement may be subject to recoupment.

HOME-DELIVERED MEALS PROVIDER REQUIREMENTS

Providers of Home-Delivered Meals must have on staff or contract with a certified dietician to ensure compliance with KDADS ~~KDOA~~ nutrition requirements for programs under the Older Americans Act.

8400. BENEFITS AND LIMITATIONS Updated 09/11

MEDICATION REMINDER SERVICES

Medication Reminder Services provides a beneficiary with a scheduled reminder for when it is time to take medications. Medication Reminder Services includes three distinct services:

- Medication Reminder is a scheduled phone call, automated recording, or automated alarm, depending on the provider's system.
- Medication Reminder/Dispenser is a device that stores a beneficiary's medication and dispenses the medication with an alarm at programmed times.
- Medication Reminder/Dispenser Installation is the placement of the medication dispenser in a beneficiary's home.

Education and assistance with Medication Reminder Services is made available to beneficiaries during implementation and as needed after implementation by the provider of this service.

MEDICATION REMINDER SERVICES LIMITATIONS

- The maintenance of rental equipment is the provider's responsibility.
- Repair or replacement of rental equipment is not covered.
- Rental of equipment is covered.
- Purchase of equipment is not covered.
- This service is limited to beneficiaries who live alone or who are alone a significant portion of the day and have no regular informal and/or formal support for extended periods of time and who otherwise require extensive routine nonphysical support including medication reminder services offered through an attendant of Personal Services.
- This service is not duplicative of any free services offered through any other agency or service.
- These systems may be maintained on a monthly rental basis even if a beneficiary is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is available in the beneficiary's home.
- Medication Reminder Services is not provided face-to-face with the exception of the installation of the medication reminder dispenser.
- Installation of the medication reminder dispenser is limited to one installation per beneficiary per calendar year.

MEDICATION REMINDER SERVICES DOCUMENTATION

Documentation must include the following:

- Service provider's name
- Service being provided
- Date of service (month and year)
- Beneficiary's first and last name
- Cost of service

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 09/11

MEDICATION REMINDER SERVICES

MEDICATION REMINDER SERVICES PROVIDER REQUIREMENTS

Any company providing medication reminder services and dispenser installation per industry standards is eligible to enroll as a Medicaid provider of Medication Reminder Services. Providers must also conform to any federal, state, and local laws and regulations that govern this service.

8400. BENEFITS AND LIMITATIONS Updated 09/11

OCCUPATIONAL THERAPY

Occupational Therapy is a treatment approach that focuses on the effects of injury on the social, emotional, and physiological condition of the individual, and evaluates an individual's balance, motor skills, posture, and perceptual and cognitive abilities within the context of functional, everyday activities. Occupational Therapy helps individuals with TBI achieve greater independence in their lives by regaining some or all of the physical, perceptual, and/or cognitive skills needed to perform activities of daily living through exercises and other related activities. When skills and strength cannot be adequately developed or improved, Occupational Therapy offers creative solutions and alternatives for carrying out daily activities. This is done by manipulating the individual's environment or by obtaining or designing special adaptive equipment and training the individual in its use. In every case, the goal of Occupational Therapy is to help people develop the living skills necessary to increase independence and, thus, enhance self-satisfaction with the person's quality of life.

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service (for example, up to six months post-injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participant's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the participant continues to make progress in his or her rehabilitation.

OCCUPATIONAL THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per beneficiary, per calendar year, for any combination of HCBS TBI therapies: behavior, cognitive, occupational, physical, and speech/language.

OCCUPATIONAL THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Beneficiaries' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Beneficiaries' files may be used for supervisory reviews, HCBS Special Service Team (HSST) reviews, quality assurance review, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Supervision of an individual working under the enrolled occupational therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

8400. BENEFITS AND LIMITATIONS Updated 09/11

OCCUPATIONAL THERAPY

OCCUPATIONAL THERAPY DOCUMENTATION (continued)

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

OCCUPATIONAL THERAPY PROVIDER REQUIREMENTS

Occupational Therapy must be provided by individuals who:

- Are licensed by the Kansas Board of Healing Arts (K.S.A. 65-5401 et seq)
  AND
- Have 40 hours of training in TBI or one year of experience working with individuals with TBI

Occupational Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

8400. BENEFITS AND LIMITATIONS Updated 09/11

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION

Personal Emergency Response System (PERS) is an electronic device which enables certain beneficiaries at high risk of institutionalization to secure help in an emergency. The beneficiary can also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once the "help" button is activated.

The case manager authorizes the need for this service based on an underlying medical or functional impairment.

Once installed, these systems can be maintained on a monthly rental basis even if the beneficiary is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the month of admission and the following two months in accordance with public assistance policy.

PERSONAL EMERGENCY RESPONSE SYSTEM LIMITATIONS

Limitations to PERS services include the following:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of equipment is not covered.
- Rental, but not purchase, of this service is covered.
- Call lights do not meet this definition.
- Maximum of two PERS installations per year.
- This service is limited to those beneficiaries who live alone, or who are alone for parts of the day, and have no regular caregiver for extended periods of time.

PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER REQUIREMENTS

Any company providing Personal Emergency Response System and installation services is qualified to provide this service. Provider requirements include:

- Must be a Medicaid-enrolled provider
- Must conform to industry standards and any federal, state, and local laws and regulations that govern this service

Note: The emergency response center must be staffed on a 24-hour/7-days-a-week basis by trained personnel.

PERSONAL EMERGENCY RESPONSE SYSTEM DOCUMENTATION

Documentation **at a minimum** must include **the following**:

- Service provider's name
- Service being provided
- Date of service (month and year)
- Beneficiary's first and last name
- Cost of service

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 09/11

PERSONAL SERVICES (AGENCY-DIRECTED AND SELF-DIRECTED)

Personal Services means assistance provided to a person with a disability with tasks that the person would typically do for himself or herself in the absence of his or her disability. Such services may include, but are not limited to, bathing, grooming, toileting, dressing, transferring, eating, mobility, housecleaning, meal preparation, laundry, shopping, and any other service that is considered an Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). Services are associated with normal rhythms of the day that can occur both in the person's home and in the greater community. This includes transportation to and from related activities (although only the time involved with transportation and not transportation costs is included in the scope of Personal Services).

Health maintenance activities, such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion, may be provided as Personal Services when they are delegated by a physician or licensed professional nurse and are documented in the POC, in accordance with K.S.A. 65-6201.

Personal Services may be provided as a self-directed or agency-directed service:

- With Personal Services Self-Directed, beneficiaries hire, train, and supervise their direct support workers. Workers are co-employed by the beneficiary and a provider of FMS chosen by the beneficiary. FMS providers are responsible for payroll-related activities and for providing information and assistance to beneficiaries to ensure that they understand the responsibilities involved with the self-direction of their attendant care. (Refer to the *HCBS FMS Provider Manual* for more information.)
- With Personal Services Agency-Directed, a qualified agency that meets all the related enrollment requirements manages all aspects of Personal Services.

PERSONAL SERVICES LIMITATIONS

Medicaid nonwaivered home health aide services for HCBS TBI beneficiaries require prior authorization.

No more than one Personal Services worker can be paid for services at any given time of the day nor is a Personal Services worker to work with more than one beneficiary at the same time and date. Exceptions must be justified and documented by the targeted case manager, such as two-person lift for safety issues. The HCBS TBI program manager must give approval for these services.

A Medicaid beneficiary is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a beneficiary cannot exceed either the daily approved number of hours or weekly approved number of hours.

Personal Services is available to HCBS TBI waiver beneficiaries up to a maximum of 10 hours per 24-hour time period. Personal Services requests exceeding 10 hours per 24-hour time period require prior authorization from the TBI program manager based on one or more of the following critical situations:

- The beneficiary is returning to the community from an institutional setting such as a nursing facility, TBI rehabilitation facility, or other medical facility. Personal Services exceeding 10 hours per 24-hour time period must be critical to the beneficiary's ability to return to and remain in the community.

8400. BENEFITS AND LIMITATIONS Updated 07/12

PERSONAL SERVICES (AGENCY-DIRECTED AND SELF-DIRECTED)
PERSONAL SERVICES LIMITATIONS (continued)

- A TBI waiver beneficiary is in a situation where there is one of the following:
    - Confirmation by Adult Protective Services that the beneficiary is a recent victim of abuse, neglect, or exploitation
    - Confirmation by Children and Family Services that the beneficiary is a recent victim of abuse or neglect
    - Documentation showing that the beneficiary is a recent victim of domestic violence

  Note: In each case, Personal Services must be critical to the remediation of the beneficiary's abuse, neglect, exploitation, or domestic violence situation and be necessary for the beneficiary to remain in the community.
- A TBI waiver beneficiary has a documented health and safety need that requires more than a total of 10 hours per 24-hour period. Related needs include two-person transfers, certain medical interventions, or supervision for elopement that is likely to result in danger to the beneficiary or others.

Planning for the use of Personal Services must occur prior to a beneficiary's return to the community or other change in living status, when applicable. In all cases, the targeted case manager must provide documentation demonstrating how Personal Services hours that exceed the 10-hour limit are necessary to remediate the previously described situations.

In accordance with statewide policy and guidelines, all TBI waiver beneficiaries are to be held to the same critical situation criteria when requesting to exceed the 10-hour limit on Personal Services through the TBI waiver.

PERSONAL SERVICES REIMBURSEMENT
A Medicaid beneficiary is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a beneficiary cannot exceed either the daily approved number of hours or weekly approved number of hours.

All Personal Services will be reimbursed to and paid to the attendant through an enrolled home health agency when services are agency-directed or an enrolled FMS provider when services are self-directed.

PERSONAL SERVICES DOCUMENTATION
~~Written~~ Documentation is required for services provided and billed to KMAP. Documentation must be legible and self-explanatory, or reimbursement may be subject to recoupment. ~~at a minimum must include the following~~:

- ~~Service being provided~~
- ~~Beneficiary's printed first and last name and signature (see Signature Limitations)~~
- ~~Attendant's printed name and signature~~
- ~~Date of service (month/day/year)~~
- ~~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~~

8400. BENEFITS AND LIMITATIONS Updated 07/12

PERSONAL SERVICES (AGENCY-DIRECTED AND SELF-DIRECTED)
PERSONAL SERVICES DOCUMENTATION (continued)

The provision of self-directed Personal Services must be documented by using KS AuthentiCare and its Interactive Voice Response (IVR) system. 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)
- Identification of the direct support worker providing the tasks
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

For agency-directed Personal Services and those limited instances where the self-directing 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
- Beneficiary's printed name (first and last) and signature on each page of documentation (see Signature Limitations)
- Direct support worker's printed name and signature on each page of documentation
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. ~~Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.~~

PERSONAL SERVICES PROVIDER REQUIREMENTS

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. An adult beneficiary's spouse or a minor beneficiary's parents must not be paid to provide this service unless granted an exception by the TBI program manager as outlined in K.A.R. 30-5-307. Any other persons who are directing or coordinating care on behalf of a beneficiary may not provide Personal Services to that same beneficiary. Agencies providing Personal Services must be licensed home health agencies and enroll with the State's fiscal agent. Individual, nonenrolled providers of Personal Services must enter into an agreement with an enrolled provider of FMS.

8400. BENEFITS AND LIMITATIONS Updated 09/11

PERSONAL SERVICES (AGENCY-DIRECTED AND SELF-DIRECTED)
PERSONAL SERVICES PROVIDER REQUIREMENTS (continued)
Medicaid providers who wish to provide payroll agent services to self-directed beneficiaries should review the Medicaid provider manual for HCBS FMS.

Any entity enrolled to provide Personal Services or serving as a FMS provider for individuals who self-direct their Personal 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.

8400. BENEFITS AND LIMITATIONS Updated 09/11

PHYSICAL THERAPY

Physical Therapy is a treatment approach that assists persons with reaching their highest level of motor functioning and mobility. Through Physical Therapy, people with TBI are assessed and receive treatment to move and perform functional activities in their daily lives and to help prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles. Treatment may involve intensive work in a variety of areas including standing, sitting, walking, balance, muscle tone, endurance, strength, and coordination. Physical Therapy also identifies and instructs the individual in the use of special equipment, when necessary, that can help the individual adapt to limited physical functioning and move more freely and independently in his or her environment.

Physical Therapy waiver services are provided when the limits of the approved Physical Therapy State Plan service (for example, up to six months post-injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participant's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the participant continues to make progress in his or her rehabilitation.

PHYSICAL THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per beneficiary, per calendar year, for any combination of the following HCBS TBI therapies: behavior, cognitive, occupational, physical, and speech/language.

PHYSICAL THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Beneficiaries' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Beneficiaries' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Supervision of an individual working under the enrolled physical therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

8400. BENEFITS AND LIMITATIONS Updated 09/11

PHYSICAL THERAPY

PHYSICAL THERAPY DOCUMENTATION (continued)

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

PHYSICAL THERAPY PROVIDER REQUIREMENTS

Physical Therapy must be provided by individuals who:

- Are licensed by the Kansas Board of Healing Arts (K.S.A. 65-2901 et seq)
  AND
- Have 40 hours of training in TBI or one year of experience working with individuals with TBI

Physical Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

8400. BENEFITS AND LIMITATIONS Updated 07/12

SLEEP CYCLE SUPPORT

This service provides non-nursing physical assistance and/or supervision during the beneficiary's normal sleeping hours in the beneficiary's place of residence. This assistance includes, but is not limited to, the following:

- Physical assistance or supervision with toileting, transferring, turning, intake of liquids, and mobility
- Prompting to take medications

Workers ~~Providers~~ can sleep and awaken as identified on the beneficiary's service plan and must provide the beneficiary with a mechanism to gain their attention or awaken them at any time. Workers ~~Providers~~ must be ready to call a physician, hospital, any identified contact person(s), or other medical personnel should an emergency arise. Workers ~~Providers~~ must submit a report to the beneficiary's targeted case manager within the first business day following any emergency response provided.

Health maintenance activities such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, range of motion, and wound care may be provided in accordance with K.S.A. 65-6201.

The beneficiary's POC must indicate a need for this service that is beyond the need for Personal Emergency Response System.

Sleep Cycle Support can be provided as a self-directed or agency-directed service.

- With self-directed Sleep Cycle Support, beneficiaries hire, train, and supervise their workers. Workers are co-employed by the beneficiary and a provider of FMS chosen by the beneficiary. FMS providers are responsible for payroll-related activities and for providing information and assistance to beneficiaries to ensure that they understand the responsibilities involved with the self-direction of their care. (Refer to the *HCBS FMS Provider Manual* for more information.)
- With agency-directed Sleep Cycle Support, a qualified agency meeting all the related enrollment requirements manages all aspects of the service.

SLEEP CYCLE SUPPORT LIMITATIONS

- Workers ~~Providers~~ must be at least 18 years of age.
- Periods of service must be at least six hours in length but cannot exceed a 12-hour period during any 24-hour period.
- No more than one Sleep Cycle Support worker can be paid for services at any given time of day. Exceptions must be justified and documented by the targeted case manager, such as two-person lift for safety issues. The HCBS TBI program manager must give approval for these services.
- Sleep Cycle Support workers can be paid for only one beneficiary per sleep cycle.

SLEEP CYCLE SUPPORT DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be legible and self-explanatory, or reimbursement may be subject to recoupment ~~clear, concise, and factual~~.

SLEEP CYCLE SUPPORT

SLEEP CYCLE SUPPORT DOCUMENTATION (continued)

~~Each visit must be documented. Documentation at a minimum must include the following:~~

- ~~Service being provided~~
- ~~Beneficiary's printed first and last name and signature~~
- ~~Date of service (month/day/year)~~
- ~~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~~
- ~~Attendant's printed name and signature~~

The provision of self-directed Sleep Cycle Support services must be documented by using KS AuthentiCare and its IVR system. 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)
- Identification of the direct support worker providing the tasks
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

For agency-directed Sleep Cycle Support services and those limited instances where the self-directing 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
- Beneficiary's printed name (first and last) and signature on each page of documentation (see Signature Limitations)
- Direct support worker's printed name and signature on each page of documentation
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

Documentation must be generated at the time of the visit. Generating documentation after-the-fact 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.~~

SLEEP CYCLE SUPPORT REIMBURSEMENT

A Medicaid beneficiary is eligible only for the number of sleep cycles per week as specified in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved sleep cycles for a beneficiary cannot exceed the number of weekly sleep cycles approved on the monthly POC.

8400. BENEFITS AND LIMITATIONS Updated 09/11

SLEEP CYCLE SUPPORT

SLEEP CYCLE SUPPORT PROVIDER REQUIREMENTS

Sleep Cycle Support must be provided by individuals who are:

- At least 18 years old
  AND
- Able to contact the appropriate person(s) in case of an emergency and provide the intermittent care the individual may need

An adult beneficiary's spouse or a minor beneficiary's parents must not be paid to provide this service unless granted an exception by the TBI program manager as outlined in K.A.R. 30-5-307.

Agencies providing Sleep Cycle Support must enroll with the State's fiscal agent. Individual, nonenrolled providers must enter into an agreement with an enrolled provider of FMS.

8400. BENEFITS AND LIMITATIONS Updated 09/11

SPEECH/LANGUAGE THERAPY

Speech/Language Therapy is the treatment of speech and/or language disorders, such as problems with the actual production of sounds and difficulty understanding or putting words together to communicate ideas. Assessment and treatment of persons with TBI may include the areas of language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills and articulation, and conversational skills. Speech/Language Therapy can also address issues related to swallowing and respiration. Goals for the person with TBI will depend on the individual's level of functioning, with the overriding focus being to regain lost skills and/or learn ways to compensate for abilities that have permanently changed so as to help the individual achieve the greatest level of independence possible.

Speech/Language Therapy waiver services are provided when the limits of the approved Speech/Language Therapy State Plan service (for example, up to six months post-injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participant's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the participant continues to make progress in his or her rehabilitation.

SPEECH/LANGUAGE THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per beneficiary, per calendar year, for any combination of the following HCBS TBI therapies: behavior, cognitive, occupational, physical, and speech/language.

SPEECH/LANGUAGE THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Beneficiaries' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Beneficiaries' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

8400. BENEFITS AND LIMITATIONS Updated 09/11

SPEECH/LANGUAGE THERAPY

SPEECH/LANGUAGE THERAPY DOCUMENTATION (continued)

Supervision of an individual working under the enrolled speech/language therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

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. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

SPEECH/LANGUAGE THERAPY PROVIDER REQUIREMENTS

Speech/Language Therapy must be provided by individuals who:

- Are licensed by the Kansas Department of Health and Environment
  AND
- Have 40 hours of training in TBI or one year of experience working with individuals with TBI

Speech/Language Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

8400. BENEFITS AND LIMITATIONS Updated 09/11

TRANSITIONAL LIVING SKILLS

Transitional Living Skills (TLS) involves the assessment and provision of community and in-home training and support services designed to prevent and/or minimize chronic disabilities while restoring the beneficiary to an optimal level of physical, cognitive, and behavioral functioning within the context of the person, family, and community. The primary purpose of TLS services is to provide opportunities for beneficiaries to develop and/or relearn skills necessary to optimize independence and enhance the individual's quality of life.

Transitional Living Skills are comprehensive in nature and, therefore, address multiple aspects of an individual's needs and goals to achieve as much independence as possible. Training follows a model in which individuals with TBI practice skills in real-life situations in their homes and communities where the skills would naturally be utilized. TLS services are designed to teach individuals how to become more self-sufficient through the application of these skills, which include but are not limited to, the following skill areas: household management, disability and social adjustment, problem solving, functional communication, transportation and mobility, resource acquisition, self-management, and community living. TLS services are expected to decrease as the individual's skills increase.

TRANSITIONAL LIVING SKILLS LIMITATIONS

- The provision of TLS is to be based on a POC and should be provided in the beneficiary's residence or in a setting where the skills would naturally occur.
- Training may be provided up to 7 days per week, with a maximum of 4 hours (16 15-minute units) daily and 3120 15-minute units per year.
- TLS services must be provided at a minimum of 4 hours (16 units) per week. (Consideration will be given to individuals when they are ill or cannot participate in TLS activities due to unforeseen circumstances.)
- Family members cannot be reimbursed for providing this service. Family members include but are not limited to parents, spouses, aunts, uncles, brothers, sisters, first cousins, and any step-family relationships.
- TLS services are to be provided on a one-on-one basis. They cannot be provided in a group setting in which multiple beneficiaries are given instruction simultaneously.
- The TLS assessment phase can be no more than 30 days.

TRANSITIONAL LIVING SKILLS DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet related training objectives. The beneficiary's files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing assessments of the effectiveness of training, and any observations that have been made. Documentation must be legible, accurate, and timely. The beneficiary's files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

8400. BENEFITS AND LIMITATIONS Updated 07/12

TRANSITIONAL LIVING SKILLS

TRANSITIONAL LIVING SKILLS DOCUMENTATION (continued)

Each visit must be documented. Documentation must include:

- Service being provided
- Beneficiary's first and last name
- Date of service (month/day/year)
- 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
- Narrative log that describes the training provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials (TLS)

Time must be totaled by actual minutes and 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 completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

TRANSITIONAL LIVING SKILLS PROVIDER REQUIREMENTS

Transitional Living Skills must be provided by a center for independent living (as defined in K.A.R. 30-5-300 (a)(21) or a licensed home health agency (as defined in K.S.A. 65-5001 et seq) enrolled to provide this service.

Individuals who provide TLS services are required to be trained by the HCBS TBI waiver provider for whom they are employed by using the ~~*SRS/DBHS/Community Supports and Services TLS*~~ *Transitional Living Skills Training Manual* on the KDADS website.

The TLS specialist candidate must complete the test that accompanies each module of the manual at a comprehensive level of 80% or better. (The TLS test can be accessed at http://ks.train.org.) The HCBS TBI waiver provider who employs the TLS specialist is responsible for ensuring that the TLS specialist has successfully completed the training and passed the test.

Individual TLS specialists must receive 28 hours of training in TBI. This mandatory curriculum is a basis for the required 28 hours of training.

Traumatic Brain Injury Waiver
Determination of Progress and Case Review

Updated 09/11

The Kansas Traumatic Brain Injury Waiver is a transitional waiver designed to provide relatively short-term services to assist people with achieving greater levels of independence. The waiver is not intended to provide permanent, long-term care services. Eligibility for the TBI waiver includes the following criterion: The individual must show the capacity to make progress in his or her rehabilitation and independent living skills.

To determine whether or not a recipient of TBI waiver services is making progress, it is essential that the individual receive one or more waiver services from which measurable progress can be evaluated (i.e., Transitional Living Skills, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Cognitive Rehabilitation, Behavior Therapy). Without this information, a consumer will be considered ineligible for waiver services. For this reason, if any 60-day period lapses when none of these services can be provided after the initial POC has been approved, either due to lack of availability or nonparticipation on the part of the consumer, the consumer's case must be transferred to an agency that can provide the service, the individual should be referred to another waiver (if appropriate), or the consumer's case should be closed.

The rehabilitative progress of people receiving TBI waiver services should be reviewed on an ongoing basis by the TBI targeted case manager (TBI TCM), along with the Transitional Living Skills specialist and therapists, if applicable. If a consumer is approaching four years of receiving waiver services and wishes to continue receiving services beyond four years, and the consumer and TBI TCM believe that the individual continues to meet the waiver eligibility criterion of making progress in rehabilitation and independent living skills, then a completed Progress Review form and other supporting documentation must be submitted to the TBI program manager, who will conduct a formal review. The review process will take into consideration the following information:

"Progress" means one or more of the following:

- Improvement with daily living skills (i.e., Activities of Daily Living, Instrumental Activities of Daily Living)
- Improvement with physical functioning
- Improvement in speech/communication
- Improvement in cognitive abilities
- Improvement in behavioral functioning

Evidence that a person is making progress includes:

- Sustained decrease in the degree of difficulty the person has with daily living skills
- Sustained decrease in the frequency of behavior issues
- Sustained decrease in the degree of difficulty with cognitive issues
- Sustained decrease in the need for supports and services
- Sustained, observable/measurable improvement with therapy
- Sustained decrease in the Long-Term Care (LTC) threshold score

Traumatic Brain Injury Waiver
Determination of Progress and Case Review

Updated 09/11

Evidence of progress is provided using:

- TBI Uniform Assessment Instrument scores
- TBI Addendum scores
- Plans of Care
- Goal Plan for independent living
- Therapy progress reports

After the TBI program manager has completed the review, the TBI TCM will be notified of the determination. If the TBI program manager confirms that the consumer continues to meet the criterion of making progress, the consumer may continue to receive waiver services, although the individual's case will be reviewed on no more than an annual basis. If, however, it is determined that the consumer is no longer making progress, a target date for transition to another waiver or closure of the case will be given.

If the TCM and the consumer disagree with the determination, a letter explaining why the consumer should continue to receive services accompanied by a completed Transition Plan document may be submitted for further consideration.

The person receiving services has the right to file a timely appeal with the Office of Administrative Hearings regarding termination of services, as explained in the Consumer Rights and Responsibilities document.

Expected Service Outcomes for Individuals or Agencies
Providing HCBS TBI Services

Updated 09/11

1. Services are provided according to the POC and Attendant Care Worksheet and in a quality manner and as authorized on the Notice of Action.

2. Services are coordinated and provided in a cost-effective and quality manner.

3. Beneficiary's independence and health are maintained, where possible, in a safe and dignified manner.

4. Beneficiary's concerns, needs, changes in health status, and so forth are communicated to the targeted case manager within 48 hours including any ongoing reporting as required by the Medicaid program.

5. Any failure or inability to provide services as scheduled in accordance with the POC and Attendant Care Worksheet must be reported immediately, but not to exceed 48 hours, to the targeted case manager.