



KANSAS MEDICAL ASSISTANCE PROGRAM
Provider Manual

HCBS
Technology Assisted

PART II
HCBS TECHNOLOGY ASSISTED PROVIDER MANUAL

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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.	

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INTRODUCTION TO THE HCBS TA PROGRAM

Updated 06/11

The Home and Community Based Services (HCBS) Technology Assisted (TA) waiver program is designed to meet the needs of individuals under 22 years of age who are chronically ill, technology-dependent, and medically fragile. These individuals have an illness or disability that requires the level of care provided in a hospital setting. In the absence of home care services, they would require admission and prolonged stay in a hospital or medical institution. Additionally, the individual requires both a medical device to compensate for the loss of vital body function and substantial, ongoing care to avert death or further disability. In order to be eligible for services, the individual must be Medicaid-eligible and meet the level of care eligibility criteria. The level of care eligibility will be assessed using the Medical Assistive Technology Level of Care (MATLOC) assessment instrument by the independent case management entity.

The HCBS TA waiver program provides opportunities for the following supports:

- Health Maintenance Monitoring
- Home Modification
- Financial Management Services (FMS)
Note: Refer to the *HCBS Financial Management Services Provider Manual* for criteria and information.
- Independent Case Management
- Intermittent Intensive Medical Care
- Long-term Community Care Attendant
 - Medical service technician (MST)
 - Personal service assistance (PSA)
- Medical Respite
- Specialized Medical Care
 - Licensed practical nurse (LPN)
 - Registered nurse (RN)

All HCBS TA waiver services require prior authorization through the program manager and electronic plan of care (POC) process for reimbursement.

The provider manual is divided into two parts. Part I of the provider manual consists of five parts: General Introduction, General Benefits, General Billing, General Special Requirements, and General TPL Payment. Part I contains information that applies to all providers, including HCBS TA providers. This provider specific section of the manual (Part II) is designed to provide information and instructions specific to providers of HCBS TA waiver program services. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

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

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

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

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

INTRODUCTION TO THE HCBS TA PROGRAM

Updated 07/12

HCBS TA enrollment

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

Documentation entry using “notes” in KS AuthentiCare

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

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

Signature requirements

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

HIPAA compliance

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

Access to records

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

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

7000. HCBS TA BILLING INSTRUCTIONS Updated 07/12

Introduction to the CMS-1500 Claim Form

Providers must use the red CMS-1500 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 Medicaid Management Information System (MMIS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information must be submitted in the correct claim fields to be recognized by the equipment.

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:

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

7010. HCBS TA SPECIFIC BILLING INFORMATION Updated 07/12

Enter diagnosis code 780.99 in Field 21, and the appropriate procedure code in Field 24D of the CMS-1500 claim form. See the Appendix section for an all-inclusive list of HCBS TA waiver codes.

Time keeping

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

Client obligation

The case management entity will need to assign the client obligation to the service provider providing the majority of the services. The case management entity must inform the provider of the client obligation assignment, and it is the responsibility of the service provider to collect this portion of the cost of service from the beneficiary. The provider does not reduce the billed amount on the claim by the client obligation, because the liability will automatically be deducted as claims are processed.

Note: Client obligation is assigned only to HCBS TA services submitted on the POC.

Third-party liability

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

- Services for Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF) ~~SRS Vocational~~ 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 website.

Plan of care authorization

The dates of service on the claim must match the dates approved on the POC and cannot overlap. The electronic POC services are prior authorized for one calendar month, beginning on the first and ending on the last day of the month. For example, services billed for May 25 - June 2 of the same year must have separate detail lines for each month (May and June).

Note: The POC is authorized on a monthly basis for a period of six months beginning with the month the beneficiary is determined eligible for the HCBS TA program. The POC is renewed every six months following eligibility redetermination. Unless otherwise authorized, the amount of services provided to the beneficiary must not exceed the amount authorized on the POC and is subject to the daily, monthly, or annual limitations for each specific service.

Same day service

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

- HCBS services provided on the date of admission, if provided prior to admission
- HCBS services provided the date of discharge, if provided following discharge
- HCBS case management provided 14 days prior to discharge

8100. COPAYMENT Issued 08/08

HCBS TA program waiver services are exempt from copayment requirements.

8300. BENEFIT PLANS Issued 08/08

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

8400. MEDICAID Updated 07/12

HCBS TA waiver program

For the purpose of this waiver program, “family” is defined as any person immediately related to the beneficiary of services. Immediately related family members are parents (including foster or adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins, and any stepfamily relationships.

The MATLOC and the Participant Service POC are used to evaluate the beneficiary’s medical, nursing, and family needs in order to identify the type of supports needed. The case management entity will work with the beneficiary or the parent/legal guardian of the beneficiary to develop an individualized POC that identifies the following:

- What type of supports and services are needed
- Who will provide the service(s)
- Amount of services to be provided
- Cost of services

The beneficiary and family can begin receiving services upon approval of the written PSPOC. In order to maintain eligibility, the beneficiary must continue to meet both financial and level of care eligibility criteria. Reassessments are conducted every six months to determine continued level of care eligibility.

Note: See the ~~Community Supports and Services (CSS)~~ HCBS TA Waiver Policy and Procedure Manual for additional information.

All HCBS TA waiver program services require prior authorization through the POC process.

Other than independent case management, services furnished to a beneficiary who is institutionalized are not reimbursable.

8400. MEDICAID Updated 07/12

Health Maintenance Monitoring

Procedure code: T1001

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

- Provide general healthcare assessment
- Assess vital signs
- Evaluate healthcare management activities
- Ensure appropriate medication administration
- Consult with the beneficiary or parent/legal guardian regarding assessment and general healthcare status
- Report assessment findings to case manager per program protocol
- May include delegation or supervision of Kansas Department for Aging and Disability Services (KDADS)-State of Kansas Department of Social and Rehabilitation Services (SRS)-approved health maintenance activities in accordance with the Nurse Practice Act

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

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

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

Documentation requirements

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

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

8400. MEDICAID Updated 04/11

Health Maintenance Monitoring Limitations

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

Reimbursement

- Payment for HMM cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- The cost of transportation to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of this service.
- Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for mental retardation (ICF/MR), or institution for mental disease (IMD) are not reimbursable.

Provider requirements

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

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

8400. MEDICAID Updated 04/11

Independent Case Management

Procedure code: T1016

Independent Case Management is required for the HCBS TA program waiver. Providers of this service assist beneficiaries in gaining access to necessary waiver and other state plan services, as well as necessary medical, social, educational and other services, regardless of the funding source. The qualified case management provider:

- Serves as the point of access for waiver services
- Conducts preliminary screening to determine if referral is appropriate
- Administers initial assessment to determine functional eligibility and reassessments to determine continued eligibility
- Identifies required service needs, including locating and coordinating services
- Develops a POC annually with clearly defined goals based on the beneficiary's level of needs
- Monitors the provision of services
- Provides technical assistance to families and service providers to carry out program operations
- Ensures the beneficiary's POC is cost-effective and meets his or her medical needs as well as basic health and safety needs
- Ensures beneficiary's freedom concerning program waiver choices, services, and providers

The POC documentation must include monitoring and follow-up activities at a minimum of every six months with documentation of progress toward stated goals. Documentation must also include whether goals are met. If a goal is not met, the case management provider must explain the reason it is unattainable, reevaluate, and propose a different approach. The reevaluation process must include the input of the beneficiary, family members, providers, and any other applicable entities. This should occur as frequently as necessary, at a minimum of every six months, to determine whether:

- Services are being furnished in accordance with the beneficiary's POC.
- Services are adequate to maintain an appropriate level of care.
- Service authorizations are adequate to support the delivery of needed services.
- Changes in the medical needs of the beneficiary or family members necessitate changes in coordination of services.
- Obstacles are impeding or limiting the delivery of services, requiring appropriate actions to eliminate them.

Documentation requirements

- Documentation must encompass information provided in the level of care instrument and the Individual/Family Needs Assessment that was used to develop the beneficiary's POC.
- Documentation must include information about the access, appropriateness, and coordination of supports and services.
- Sources of information can include contacts with the beneficiary, family members, legal representatives, service providers, and other interested parties.
- Documentation must provide the necessary detail to meet federal and state requirements.
- Documentation must be legible, accurate, and timely.

Note: Beneficiary's files may be used for supervisory reviews, home care review audits, quality assurance reviews, and issues related to client obligations.

8400. MEDICAID Updated 07/12

Independent Case Management

Documentation requirements (continued)

- Documentation, at a minimum, must include the following:
 - Initial assessment and reassessment
 - Assessments dated and signed by the case manager, parent/legal guardian, and physician or medical provider
 - Notice of Actions
 - Services being used and provided
 - Service provider's printed or typed name and signature
 - Location of service provided
 - Beneficiary's printed or typed full name, identification number and demographic information
 - Date of service (beginning and ending with MM/DD/YY)
 - Signature of parent or legal guardian with the authority to provide consent to receive services
 - Start and stop time for each visit, including AM/PM or using 2400 clock hours
- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable.

Limitations

- Providers of this service may not provide other direct **waiver** services to beneficiaries for whom they provide case management. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which a beneficiary has been referred.
- This service may be provided up to 14 days prior to a beneficiary's discharge from an acute care hospital/institution in order to conduct care coordination activities for the beneficiary returning home or entering a community-based setting. The case manager must assist the beneficiary in activities necessary for the beneficiary to move from an institutional setting to a community-based setting.
- Case management is allowed 10 hours per month with the maximum allowable of 480 units per calendar year per beneficiary.
 - One unit is equal to 15 minutes.
 - Requests to exceed the monthly and annual limit may be submitted for prior authorization by the program manager-SRS, DBHS/CSS.
 - The request to exceed the case management limit must meet the established criteria.
- The cost of transportation to conduct an initial and reassessment to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of this service.
- Other than Independent Case Management, services furnished to a beneficiary who is institutionalized are not reimbursable.
- The majority of contacts must occur in customary and usual community locations where the beneficiary lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.

8400. MEDICAID Updated 07/12

Independent Case Management Reimbursement

Payment for case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider requirements

- Be a KMAP-enrolled provider for HCBS TA waiver program services in order to provide and bill for case management services
- Be an advanced registered nurse practitioner (ARNP) or RN with a bachelor's degree and two years of experience in the nursing field
- Participate in the TA program waiver and MATLOC assessment training to become familiar with the policies, procedures, rules, regulations, and services available
Note: Upon completion of training, a certificate of completion will be issued to certify the case management entity has completed the training.
- Maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including, but not limited to:
 - Professional license/certification
 - Adherence to DBHS/CSS training and professional development requirements
 - Maintenance of clear background as evidenced through KBI, APS, CPS, KSBN, and DMV

Note: Applicant must meet provider requirements and receive approval by **KDADS SRS** to provide HCBS TA waiver program case management services.

8400. MEDICAID Updated 04/11

Intermittent Intensive Medical Care

Procedure code: T1002

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

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

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

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

Documentation requirements

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

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

KANSAS MEDICAL ASSISTANCE PROGRAM
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BENEFITS & LIMITATIONS

8400. MEDICAID Updated 04/11

Intermittent Intensive Medical Care **Limitations**

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

Reimbursement

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

Provider requirements

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

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

8400. MEDICAID Updated 06/11

Specialized Medical Care

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

This service provides long-term nursing support for medically fragile and technology-dependent beneficiaries. The required level of care must provide medical support for beneficiaries needing ongoing, daily care as in a hospital. The intensive medical needs of the beneficiary must be met to ensure that he or she can choose to live outside of a hospital or institutional setting.

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

- 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.
- The medical necessity of this service is subject to the nursing acuity assessment as identified in the MATLOC instrument and the Individual/Family Needs Assessment used in the development of the beneficiary's POC.
- Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.

Documentation requirements

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

8400. MEDICAID Updated 04/11

Specialized Medical Care

Documentation requirements (continued)

- Signature of parent or legal guardian with the authority to provide consent to receive services
- Start and stop times, including AM/PM or using 2400 clock hours
- Time spent must be clearly documented in the notes. Providers are responsible to ensure that the service was provided prior to submitting claims.
- Documentation must be clearly written and self-explanatory, or services billed may not be reimbursed.
- Documentation must be created during the time period of the billing cycle. Documentation generated after this time is not acceptable.

Limitations

- Providers of this service cannot provide other direct services to beneficiaries for whom they provide Specialized Medical Care.
- Specialized Medical Care provided by an entity under the Professional Services Under Defined Conditions (PSUDC) agreement cannot provide Medical Respite.
- Providers of Specialized Medical Care are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a HHA licensed by KDHE.
- Specialized Medical Care is limited to 252 hours or 1008 units per month per beneficiary.
 - One unit is equal to 15 minutes.
 - Requests to exceed the monthly and annual limit may be submitted to the HCBS TA program manager at CSS for prior authorization.
 - The request to exceed the service limits must be medically necessary and meet the established criteria.
- The cost of transportation to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of this service.
- The majority of contacts must occur in customary and usual community locations where the beneficiary lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD are not reimbursable.
- This service may begin upon approval of HCBS TA waiver program and services.
- The case management entity will coordinate and communicate the effective date of service.

Reimbursement

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

8400. MEDICAID Updated 04/11

Specialized Medical Care

Provider requirements

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

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

8400. MEDICAID Updated 07/12

Long-Term Community Care Attendant

Procedure codes: **T1004 Medical service technician – agency-directed**
 T1019 Personal service attendant – self-directed

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

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

The functions of an attendant include but are not limited to assisting with:

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

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

Agency-directed attendant services will be coordinated by the independent case manager and submitted in the electronic POC for prior authorization and approval.

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

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

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

Documentation requirements

- Documentation must encompass information provided in the MATLOC instrument and the Individual/Family Needs Assessment that was used to develop the beneficiary's POC related to the service being provided.

8400. MEDICAID Updated 07/12

Long-Term Community Care Attendant

Documentation requirements (continued)

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

Long-Term Community Care Attendant - agency-directed

Medical Service Technician (MST)

Documentation, at a minimum, must include the following:

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

Long-Term Community Care Attendant - self-directed

Personal Service Attendant (PSA)

Documentation, at a minimum, must include the following:

- MATLOC signed by the physician or medical provider
- Notice of Action detailing the type of service, scope, frequency, and duration of services to be provided
- Completed PSA Skill Checklist demonstrating delegation and training provided and signed by the beneficiary or parent/legal guardian
- Documentation of changes in the beneficiary's medical status or care
- Service provider's printed or typed name and signature
- Location of service provided

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Long-Term Community Care Attendant

Long-Term Community Care Attendant - self-directed (PSA)

- Beneficiary's printed or typed full name, identification number and demographic information
- Date of service (beginning and ending with MM/DD/YY)
- Signature of parent or legal guardian with the authority to provide consent to receive services
- Start and stop times for each visit, including AM/PM or using 2400 clock hours

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

Limitations

- An attendant cannot perform any duties not delegated by the individual with the authority to direct services or duties as approved by the beneficiary's physician. A service or duty must be identified as a necessary task in the POC.
- The parent or legal guardian of the minor beneficiary cannot be his or her attendant.
- Attendant care is limited to 372 hours or 1488 units per month per beneficiary. One unit is equal to 15 minutes.
- PSA and/or MST service(s) can be provided up to a maximum of 12 hours or 48 units per day.
- It is the expectation that beneficiaries needing assistance with ADL tasks who live with a parent or guardian capable of performing these tasks will rely on this informal, natural support for this assistance. Otherwise, there must be extenuating or specific circumstances documented in the POC. As such, attendants should not assist with the following:
 - Lawn care
 - Snow removal
 - Shopping
 - Ordinary housekeeping (which should be done along with the household responsibilities of those living with the beneficiary)
 - Meal preparation (during the times when normal meal preparation occurs in the household)
- The majority of contacts must occur in customary and usual community locations where the beneficiary lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD are not reimbursable.
- The cost of transportation to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to providers of these services.

Reimbursement

Payment for Long-Term Community Care Attendant may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8400. MEDICAID Updated 04/11

Long-Term Community Care Attendant

Provider requirements

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

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

MST – agency-directed

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

PSA – self-directed

- Have a high school diploma or equivalent
- Be 18 years of age or older
- Meet the family’s qualifications
- Reside outside of the beneficiary’s home
- Complete the necessary skill training needed in order to care for the beneficiary as recommended by the parent or legal representative and qualified medical provider
- Be a KMAP-enrolled provider authorized to provide HCBS TA waiver program services
- Meet the skill training documentation required by **KDADS-SRS**

8400. MEDICAID Updated 06/11

Long-Term Community Care Attendant

All payments for personal service attendant (self-directed) care will be arranged by a FMS provider with the beneficiary's or parent/legal guardian's written authorization of the purchase. The beneficiary will have complete access to choose any qualified FMS provider. The provider must meet the qualifications as specified in the *FMS Provider Manual*.

Each individual qualified provider will not be given a separate provider agreement but may choose to contract with any qualified provider agency or through a FMS agency.

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

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

8400. MEDICAID Updated 04/11

Medical Respite

Procedure code: T1005

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

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

Documentation requirements

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

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Medical Respite

Limitations

- Providers of Medical Respite are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a HHA licensed by KDHE.
- Medical Respite is limited to 168 hours or 672 units per calendar year.
- The cost of transportation to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to the providers of this service.
- The majority of contacts must occur in customary and usual community locations where the beneficiary lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD are not covered.

Reimbursement

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

Provider requirements

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

8400. MEDICAID Updated 04/11

Home Modification

Procedure code: S5165

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

Documentation Requirements

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

Covered Services

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

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Home Modification

Limitations

- Services must be provided within specified local and state building codes.
- Modifications are made within the existing structures and must not result in addition of square footage to the existing structure.
- Home modification services are reimbursed at one unit equal to one purchase, limited to a lifetime maximum of \$7,500.
- All services provided must meet the local city and state building codes.
- The property must be owned by the beneficiary or his or her parent/legal guardian and occupied by the beneficiary.
- Home modification needs are assessed by the independent case manager, using the MATLOC instrument. The independent case manager and the beneficiary or parent/legal guardian must obtain and submit to ~~KDADS-SRS~~ two bids for the equipment or modification according to policy guidelines.
- The cost of transportation to and from the beneficiary's place of residence and other service sites or places in the community is included in the reimbursement rate paid to the providers of this service.
- The majority of contacts must occur in customary and usual community locations where the beneficiary lives, attends school and/or childcare, and socializes. Services provided in a home school setting must not be educational in purpose.
- Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD are not covered.

Reimbursement

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

Provider Requirements

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

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

APPENDIX

Codes

Updated 04/11

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

T1001	<u>HEALTH MAINTENANCE MONITORING – RN/LPN</u> One unit equals one visit.
S5165	<u>HOME MODIFICATION</u> Per service
T1002	<u>INTERMITTENT INTENSIVE MEDICAL CARE – RN</u> One unit for up to 15 minutes, not to exceed 16 units per day
T1016	<u>INDEPENDENT CASE MANAGEMENT</u> One unit for up to 15 minutes
T1004	<u>LONG-TERM COMMUNITY CARE ATTENDANT – MEDICAL SERVICE TECNICIAN (AGENCY-DIRECTED)</u> One unit for up to 15 minutes
T1019	<u>LONG-TERM COMMUNITY CARE ATTENDANT – PERSONAL SERVICE ATTENDANT (SELF-DIRECTED)</u> One unit for up to 15 minutes
T1005	<u>MEDICAL RESPITE – RN/LPN</u> One unit for up to 15 minutes
T1000	<u>SPECIALIZED MEDICAL CARE – RN/LPN</u> One unit for up to 15 minutes