

**September 2006**

**Provider Bulletin Number 636**

## **General Providers**

### **Beneficiary Identification Card Update**

Effective May 5, 2006, the Children and Family Policy Division (CFP) Contractor field no longer appears on the beneficiary identification cards. A sample card is below.

STATE OF KANSAS HEALTH INSURANCE CARD	
EFFECTIVE PERSON COVERED	10-01-2005 — 10-31-2005
ID#	SMITH, A 00101000001
BENEFIT PLAN	TXIX
LIVING ARR.	HCPD
KBH EXAM:	LAST 08-15-2001
EYE EXAM:	08-15-2001
PRIMARY PROVIDER	
LOCK-IN PROVIDER(S)	
DATA CONTAINED ON THIS CARD MAY HAVE CHANGED SINCE 10/20/2005	
TPL/HMO COV	MEDICARE A & B & D
POLICY #	123456789HBB
COV	
POLICY #	
COV	
POLICY #	
PC	30,34,43
BLUE	

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at <https://www.kmap-state-ks.us>. For the changes resulting from this provider bulletin, select the following: *General Benefits Provider Manual*, page 2-51; *Behavior Management Provider Manual*, page 8-7; *CMHC Provider Manual*, page 8-5; *Psychology Provider Manual*, page 8-4; *Hospital Provider Manual*, page 8-20; and *Professional Services Provider Manual*, page 8-9.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

## **2900. CHILDREN AND FAMILY SERVICES (CFS) CONTRACTORS**

Updated 9/06

Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to the Kansas Medical Assistance Program and will be reimbursed at the approved Medicaid rate. Prior authorization and other restrictions apply.

**NOTE:** In some cases, the assignment to a contractor terminates, yet still appears on the medical card. If you feel this assignment information is incorrect, please contact the CFS Contract Specialist at the local SRS office for verification of assignment information. This verification will be provided to you on a “Behavior Management/Mental Health Provider Proof of Denial” form #CFS 4025. This Proof of Denial form (#CFS 4025) must be attached to a paper claim for processing.

The following is a list of the services covered under the CFS contracts:

### **Adoption Services**

All services provided by a Behavior Management Provider  
Pre Admission Assessment—Behavior Management, H0002

### **Family Preservation Services**

All services provided by a Behavior Management Provider  
Community Psychiatric Supportive Treatment, H0036  
Family Therapy, 90847  
Group Therapy, 90853  
Individual Community Support, T1019  
Individual Therapy, 90804 90819, 90821 90824, 90826 90829  
Psychological Testing, 96100  
Targeted Case Management, T1017  
In Home Family Based Services, S9489  
Mental Health Attendant Care (CMHC), T1019

## **8400. Updated 9/06**

### **Attendant Care, (continued):**

Attendant care may be provided when the consumer is residing in his/her own home, biological family home, adoptive home, or foster home. Attendant care cannot be provided when the consumer resides in residential placement or a group home.

The behavior management attendant must meet the following criteria:

- Be 18 years of age or older,
- Be employed by the provider agency which will bill for the service,
- Pass a security check,
- Completed a 40-hour basic training program through the provider agency,
- Have a basic knowledge of normal and abnormal behavior,
- Evidence an ability to relate to emotionally disturbed children.

A multidisciplinary treatment plan shall be developed to meet the consumer's needs. Hours of service delivered must be documented and retained in the consumer's file.

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~~Refer to Section 2900 of your General Provider Manual for an all inclusive list of the categories of service covered under the CFS contract.~~

### **In-Home Family Treatment:**

In-home family treatment providers must have a certificate or degree showing advanced training in the delivery of family based services and be at least one of the following:

- An Accredited Family Service Agency
- A Licensed Child Placing Agency
- A Licensed Masters Degreed Social Worker
- A Licensed Physician
- A Licensed Psychologist
- A Registered Marriage and Family Therapist
- A Licensed Professional Counselor

The local SRS Area Office Social Services contract specialist will ensure the provider has met the above requirements before issuing the "Provider Approval" letter. A written "Client Service Agreement" between the provider, the consumer's family, and the SRS area office must be obtained for each individual to whom in-home treatment is provided. This agreement indicates that the child (or family) is in need of intervention in an effort to avoid intensive out-of-home services. The hours of service covered are determined on a case-by-case basis and are specified in the "Client Service Agreement". This agreement must be retained in the consumer's file at the provider agency. Only the number of hours specified in the agreement for in-home family treatment shall be reimbursed. Reimbursement for hours of service provided beyond those listed in the service agreement will be recouped.

## **KANSAS MEDICAL ASSISTANCE BEHAVIOR MANAGEMENT PROVIDER MANUAL BENEFITS & LIMITATIONS**

## **8400. Updated 9/06**

### **Case Consultations:**

Case consultations are covered when provided by a physician (or by an ARNP/PA with the performing provider number noted). Written consultation of the consultation is required.

Consultations are not based on time but rather on the extent of the consultation. Reference the CPT manual to determine criteria for various service levels. The following Medicaid limitations apply:

- Consultations for a new patient are not covered if a consultation has been paid to the same provider for the same patient in the previous 60 days.
- Inpatient consultations for established patients are limited to one consultation per 10 days per provider, per diagnosis, unless medical necessity documents otherwise.
- Outpatient and in-office consultations for established patients are limited to one consultation every 60 days, per provider, per diagnosis unless medical necessity documents otherwise.

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### **Community Psychiatric Supportive Treatment (CPST):**

CPST shall be face-to-face interventions with the individual. In addition, a majority of these contacts must occur in customary and usual community locations where the person lives, works, or socializes. All interventions provided shall be related to specific goals set forth in the consumer's treatment plan. Documentation in progress notes is required to support the CPST intervention. CPST interventions include the following:

- Assistance in improving symptom self-management, which shall have as its goal the identification and minimization of the negative effects of psychiatric symptoms or emotional disturbances which interfere with an individual's daily living, financial management, academic progress, personal development, family and/or interpersonal relationships and community integration. This may include counseling the individual to recognize symptoms for self-management.

## **BENEFITS AND LIMITATIONS**

### **8400. MEDICAID**

**Updated 9/06**

Psychological services are covered when provided by a Kansas licensed psychologist (Ph.D.). The psychologist must bill Medicaid directly for services. Medicaid does not reimburse psychologists to supervise someone else who is doing therapy. Uncertified assistants may be utilized in administering tests.

#### **Adult Care Home Services:**

Individual and group psychotherapy services provided in an adult care home are covered. Scheduled face-to-face meetings involving consultation concerning behavior management or problems associated with a group of NF/MH (Nursing Facility/Mental Health) patients is covered if ordered by the psychiatrist (M.D.). The meetings may include treatment staff, collaterals, or other agency representatives of the patient, including ICF/MH staff. A separate claim form must be submitted for each patient. Psychological testing/assessment is allowed in an ICF/MR (Intermediate Care Facility/Mental Retardation) facility.

**Mental Health Services for NF/MH Consumers:** Mental health services to consumers residing in a Nursing Facility for Mental Health are non-covered. Exception will be made for up to eight hours of therapy (90806) for individuals in acute trauma and for Targeted Case Management and Community Psychiatric Supportive Treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are psychiatric diagnostic interview (90801), and psychiatric pre-admission assessments (Y9514) which require no special approval.

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#### **Family Therapy:**

Therapy that involves treatment of the family as a "system" with family being the focus of attention and change, specifically including children (may refer to adult children). The individual who is the Medicaid cardholder must be present during the delivery of service.

Family therapy is covered when there is a treatment plan containing a psychiatric diagnosis and goals of treatment. This limitation is monitored post-pay and requires the provider to document, in legible writing, the amount of time spent in therapy, major issues covered and changes in medication, diagnosis, condition, treatment plan or course of treatment. The provider must document that a review of the treatment plan has been conducted every three months.

**The Patient Self-Determination Act, Section 1902(w) of the Social Security Act**

This federal law, codified at 42 U.S.C. Sec. 1396a(w), was effective December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the State law about advance directives. This description was written by the Health Care Policy Section of the Kansas Department of Social and Rehabilitation Services to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your physician or attorney.

Third Edition: January 14, 2003

**Abortions:**

Abortions are covered only under the following conditions:

- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.
- If the pregnancy is the result of an act of rape or incest.

The physician must complete the form below to certify that the woman's physical health is in danger, or that this pregnancy is a result of rape or incest. A copy of the form can be found in the forms section at the end of this manual. The form may be photocopied for your use. All blanks **must** be completed, including the patient's complete address.

Claims submitted for abortions due to rape or incest must be accompanied by a statement signed by the physician stating that he/she was informed by the patient that the pregnancy was the result of rape or incest. No further documentation is required to process the claim. However, all pertinent information must be retained with the medical record.

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### **Community Mental Health Centers (CMHC):**

When a physician desires to send a consumer to a Community Mental Health Center, he/she should call the center before making this referral. Each center has its own referral requirements, initial appointment procedures, and vary in services provided. Community Mental Health Center services are covered for outpatient treatment and partial hospitalization.

### **Consultations:**

Only one initial consultation is covered within a sixty (60) day period per consumer by the same provider.

### **CPAP For KBH Participants:**

Continuous positive airway pressure (CPAP) is a covered service for **KAN Be Healthy participants**. Prior authorization (PA) for medical necessity is required. Criteria for medical necessity is:

- 1) Infant Respiratory Distress Syndrome in newborns (e.g., Hyaline Membrane Disease) or
- 2) Morbid obesity with documented sleep apnea.
  - 30% over average weight for height, sex, and age,
  - Sleep study with documented arterial oxygen (O<sub>2</sub>) saturation of 80% or less. A printout of the documented arterial O<sub>2</sub> saturation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.
  - Documented participation in a weight reduction program. This documentation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.

### **Dental:**

For information about covered dental benefits, contact KMAP Dental Services at 1-800-933-6593. ~~Doral Dental Services at 1-800-436-5288 or [www.doralusa.com](http://www.doralusa.com)~~

### **Orthodontia:**

For information about covered orthodontia benefits, contact KMAP Dental Services at 1-800-933-6593. ~~Doral Dental Services at 1-800-436-5288 or [www.doralusa.com](http://www.doralusa.com)~~