Kansas Medical Assistance Program

October 2006 **Provider Bulletin Number 689**

HCBS MRDD Providers

Screening – Unit Change

Effective with processing date September 1, 2006, and retroactive to dates of service on and after July 1, 2006, Service Assessment/Plan of Care Development Waiver (T2024) will be billed at one unit = one assessment.

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, please view the *HCBS MRDD Screening Manual*, pages 7-2 and 8-2.

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.

7010. MR/DD SCREENING SPECIFIC BILLING INFORMATION
Updated 10/06

Enter procedure code T2024 (Screening - MR/DD) in field 24D of the HCFA-1500 claim form.

One unit = one assessment ~~visit~~

Client Obligation:

If a case manager has assigned client obligation to a particular provider and informed that 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.

One Plan of Care per Month:

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

Example:

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

Overlapping Dates of Service:

The dates of service on the claim must match the dates approved on the plan of care and cannot overlap. For example, there are two lines on the plan of care with the following dates of service: July 1 - 15 and July 16 - 31. If you were to bill service dates of July 8 - 16, the claim would deny because the system is trying to read two different lines on the plan of care. For the first service line, any date that falls between July 1 - 15 will prevent the claim from denying for date of service.

Same Day Service:

For certain situations, HCBS services approved on a plan of care and provided the same time a consumer is hospitalized or in a nursing facility may be allowed. Situations are limited to:

- HCBS services are provided on the date of admission, if provided prior to the beneficiary's admission
- HCBS services are provided on the date of discharge, if provided following the beneficiary's discharge
- HCBS Targeted Case Management are provided within 30 days prior to discharge

8400 Updated 10/06

Recordkeeping:

Documentation Requirements:

Written documentation is required for services provided and billed to the Kansas Medical Assistance Program. Documentation at a minimum must include the following:

- Name of the service being provided
- Consumer's name
- Screener's name and signature
- Date of service (MM/DD/YY)
- Start time for each visit; include AM/PM or utilize 2400 clock hours
- Stop time for each visit; include AM/PM or utilize 2400 clock hours
- Brief entry indicating the Basis assessment has completed
- A copy of the assessment

Documentation must be created at the time of the visit. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims.

Documentation must be clearly written and self-explanatory, reimbursement may be subject to recoupment.

Limitations:

Beneficiaries are covered for only one initial screening and an annual screening. ~~not to exceed four hours.~~

HCBS MR/DD is available to Medicaid Program beneficiaries who:

- Are 5 years old or older,
- Are mentally retarded or otherwise developmentally disabled,
- Meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MR/DD) screening, and
- Choose to receive HCBS MR/DD rather than ICF/MR services.

HCBS MR/DD is available to minor children, ages 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.

HCBS MR/DD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.