KMAP Audit Protocols

Medicaid providers are responsible for developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. The protocols included in the Kansas Medical Assistance Program (KMAP) manuals are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the Kansas Department of Health and Environment (KDHE)-Department of Health Care Finance (DHCF) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person, including a corporation. Additionally, nothing in the protocols alters any statutory or regulatory requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

The audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and therefore are not a substitute for a review of the statutory and regulatory law, provider manual, or provider agreement.

The audit protocols do not limit or diminish KDHE-DHCF's authority to recover improperly expended Medicaid funds and KDHE-DHCF may amend audit protocols as necessary to address identified issues of noncompliance. Additional reasons for amending protocols include, but are not limited to, responding to a state fair hearing decision, litigation decision, directives from the Centers for Medicare and Medicaid Services (CMS), or statutory or regulatory change.

KMAP HCBS Protocols

Finding	Criteria	Regulatory References
Billing – time billed exceeds documented activity (documentation does not support time billed)	The difference between the amount of time billed and the amount of time documented will be disallowed if the amount paid exceeds the amount of time documented.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits Fee-for-Service (FFS) Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Section 8400 TBI, Section 8400
Billing – time billed exceeded hours authorized on the plan of care (POC)	Time billed in excess of those authorized will be disallowed. This includes time billed in excess of the daily/weekly frequency. Only the excess time will be disallowed.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Sections 7010 and 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Sections 7010 and 8400 TBI, Sections 7010 and 8400
Billing – services/ activities/tasks billed are not authorized in the POC and Personal Care Services worksheet	The payment for services/activities/tasks will be disallowed if not approved in the POC and Personal Care Services worksheet. For example, time billed and paid for bathing would be disallowed if not authorized on the Personal Care Services worksheet.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Section 8400 TBI, Section 8400

Billing – HCBS billed while beneficiary is hospitalized, in a nursing facility, or otherwise unable to receive services	HCBS billed after the beneficiary is admitted and HCBS billed prior to discharge will be disallowed. The exception is for personal emergency response monthly charge.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Sections 7010 and 8400 FE, Sections 7010 and 8400 FMS, Sections 7010 and 8400 I/DD, Sections 7010 and 8400 PD, Sections 7010 and 8000 TA, Sections 7010 and 8400 TBI, Sections 7010 and 8400
Billing – After beneficiary's death	Claims must be submitted only for payment for services actually furnished. Payment will be disallowed if the claim is for a date of service after the beneficiary's death.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Billing FFS Provider Manual, Section 5600
Billing – multiple personal care services workers billed overlapping time(s) to individual beneficiaries	All time(s) billed by multiple personal care services workers which overlap same date/same time to the same beneficiary will be disallowed.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TBI, Section 8400
Billing – personal care services worker billed overlapping time(s) to multiple beneficiaries	All time(s) billed by the personal care services worker which overlap the same date/same time to multiple beneficiaries will be disallowed.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TBI, Section 8400

Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payer.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Documentation – Signature authenticity	Payment will be disallowed for the paid services if the authenticity of the beneficiary's/beneficiary representative's signature is questioned. Authenticity will be questioned if the beneficiary's signature varies from worker to worker or if the signature does not match the signature on file.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Section 8400 TBI, Section 8400
Documentation – missing or insufficient documentation of time billed	If documentation to support the amount of time billed is not available for review the time billed will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 FMS, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Section 8400 TBI, Section 8400
Services – excluded relative performed services	Payment made for services performed by the adult beneficiary's spouse or minor beneficiary's parent will be disallowed unless regulatory and program requirements for an exception are met.	42 CFR 440.167 KAR 30-5-307 "Family reimbursement restriction" KMAP Provider Agreement KMAP HCBS FFS Provider Manuals: Autism, Section 8400 FE, Section 8400 I/DD, Section 8400 PD, Section 8000 TA, Section 8400 TBI, Section 8400

Excluded provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 “Provider participation requirements” KAR 30-5-67 “Disallowance of claims for services generated by providers ineligible for participation” KAR 30-5-70 “Payment for medical expenses for eligible recipients” KMAP Provider Agreement
Unmet program requirements for Ordering, Referring, Attending, Prescribing, and Sponsoring providers	Effective April 1, 2019, all physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid beneficiaries (or other professionals who provide services under the state plan) are required to enroll with KMAP.	42 CFR 455.410 42 CFR 455.440 KMAP General Benefits FFS Provider Manual, Section 2000

KMAP Home Health Agency Protocols

Finding	Criteria	Regulatory References
Billing – After beneficiary's death	Claims must be submitted only for payment for services actually furnished and which are medically necessary. Payment will be disallowed if the claim is for a date of service after the beneficiary's death.	KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-63 "Medically necessity" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Billing FFS Provider Manual, Section 5600 KMAP Home Health Agency FFS Provider Manual, Section 8400
Billing – Cancelled visits or appointments not kept	Payment will be disallowed for a "no show" or cancelled visit.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payor. All reimbursement for claims submitted with an inappropriately applied GY modifier will be recovered.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Billing – Billed KMAP before services were authorized	If the provider began billing before the POC was signed by the licensed practitioner, the paid claim will be disallowed. This applies to the original POC, all subsequent POCs, modifications to the POC, and care plans resulting from a verbal order. All identified services billed prior to the date of the practitioner's signature on the order, which covers the approved and signed POCs for the time period of the service, will be disallowed.	42 CFR Section 484.18(b) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix III
Billing – Billed for performance of tasks/services not ordered	If the provider billed for tasks/services that were not included in the POC/medical orders, the services will be disallowed.	42 CFR Section 484.18 42 CFR Section 484.18(a) 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix III
Billing – Billed for services in excess of ordered hours/visits	If the provider billed more hours/nursing or therapy visits than the POC/medical orders authorized, the payment for the hours/visits exceeding the order will be disallowed. If the number of hours on any date of service exceeds the total maximum number of hours per visit on the approved POC (and no supplemental order was obtained), the additional hours will be disallowed. The disallowed service or units of service should be a service that exceeded the ordered plan frequency for the calendar week that is used by the provider. If additional time is necessary, the justification for the extra time must be documented.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix III

KMAP Home Health Agency Protocols

Billing – Billed for services in excess of ordered hours/visits (continued)	KMAP will consider exceptional situations, where ordered services were exceeded for good cause (situation must be documented).	
Billing – Billed for services performed by another provider/entity	If the services billed by the provider are duplicative (already paid for by Medicaid or by another entity), the paid claim will be disallowed. Specific case circumstances will be evaluated through review of the record. Guidance will be sought from the appropriate program division as needed.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400
Billing – Billed incorrect code	If the procedure code billed is not the correct procedure code for the services provided, the difference between the appropriate claim amount and the paid claim will be disallowed.	KMAP Provider Agreement KMAP Home Health Agency Provider Manual, Appendix III
Documentation – Missing required documents	Payment will be disallowed for the service if documentation to support the service provided is missing or not available for review. For example: • Time sheet documenting home health aide's services • Home Health Certification & Plan of Care (CMS 485) • Skilled nursing notes • Medication Administration Record (MAR) • Therapy notes • Home health aide POC • Evidence of supervisory visits by the RN	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Missing or insufficient documentation of hours/visits billed	If there is not a chart, the aide failed to document the hours of service billed, or the professional staff failed to document the visit, the portion of the paid claim that was not documented will be disallowed. The nature of the facts surrounding the missing records or claims for services not rendered should be evaluated for additional action.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Paid services not supported	Payment will be disallowed if clinical notes do not support the services billed. For example, payment will be disallowed for a skilled nursing visit code if the documentation supports only a pre-pour of medication for the week. The documentation must include a full assessment of the beneficiary's medical and behavioural status, as well as notes addressing the beneficiary's understanding of the drug therapy and his or her continued ability to self-administer the medications.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Documentation – Medical necessity	Payment will be disallowed for the service when documentation in the medical record fails to support that a paid service was medically necessary.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-63 Medical necessity KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700

KMAP Home Health Agency Protocols

Documentation – Missing POC/order	If there is not a POC/medical order in the record for the relevant date of service, the paid claim will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) 42 CFR Section 484.18 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III
Documentation – Home health aide services POC	Payment for home health aide services will be disallowed if the written POC for home health services does not meet the requirements.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Section 8400
Documentation – Medical need for tasks/services not documented in the record	The record, pertinent to the date of service, will be reviewed to determine if the patient's medical need for the authorized tasks or services was documented as required. If the medical need for the authorized tasks or services is not supported by the case record documentation, the paid claim will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Section 8400
Documentation – Medical need for hours billed not documented in the record	The record, pertinent to the date of service, will be reviewed to determine if the patient's medical need for the hours billed was documented as required. The time spent providing services to the patient must be supported by the documentation in the record. If the medical need for the hours billed was not documented in the record, the paid claim will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Section 8400
Documentation – Failed to obtain authorized practitioner's signature	If the POC/medical orders were not signed, the paid claim will be disallowed. Signed medical orders are required prior to the start of care, a change in the POC, or recertification.	Social Security Act Section 1902(a)(27)(A),(B) 42 CFR Section 484.18(b) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III

Documentation – POC/order not signed by an authorized practitioner	If the practitioner was not authorized to sign the POC/medical orders, the paid claim will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) 42 CFR Section 484.18 KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Introduction FFS Provider Manual, Introduction KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III
Documentation – Verbal orders not signed	Payment will be disallowed for services that are based on a verbal or telephone order if the order is not later documented, signed, and dated by a licensed practitioner authorized to issue the order.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III
Documentation – Initial assessment not documented or late	The provider must conduct an initial assessment visit to determine the immediate care and support needs of the beneficiary. If there is not an initial assessment in the record for the relevant date of service or the assessment is late, the paid claim will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) 42 CFR Section 484.55(a)(1) 42 CFR Section 484.55(a)(2) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III
Documentation – Comprehensive assessment not documented or late	If there is not a comprehensive assessment in the record for the relevant date of service or the comprehensive assessment was late, the paid claim will be disallowed. The comprehensive assessment must be completed in a timely manner. The comprehensive assessment must be updated and revised (including the Outcome and Assessment Information Set [OASIS]) as frequently as the patient's condition warrants.	Social Security Act Section 1902(a)(27)(A),(B) 42 CFR Section 484.55(b)(1) 42 CFR Section 484.55(d)(1)(i)-(iii) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III
Documentation – Comprehensive reassessment	Payment for services will be disallowed if the paid service is for a comprehensive reassessment that was not completed at a minimum of every 60 days, beginning with the start date of the new patient care plan.	Social Security Act Section 1902(a)(27)(A),(B) 42 C.F.R. § 484.55(d)(1) KAR 30-5-59(c)(4) "submit claims only for covered services provided to consumers" KAR 30-5-61a "Withholding of payments to medical providers" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Appendix III

Services – Initial assessment does not meet the required standards	The initial assessment and the record, pertinent to the date of service, will be reviewed to determine if the standards set forth in the regulations were met. The assessment performed during the initial visit (prior to admission) must indicate that the patient's health and supportive needs could safely and adequately be met at home and the patient's condition required the services of the agency. If the initial assessment does not meet the required standards, the paid claim will be disallowed.	42 CFR Section 484.55(a)(1) 42 CFR Section 484.55(a)(2) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400
Services – Comprehensive assessment does not meet standards	The comprehensive assessment and the record, pertinent to the date of service, will be reviewed to determine if the standards set forth in the federal regulations were met. The comprehensive assessment must be patient-specific and: accurately reflect the patient's status; include information to demonstrate the patient's progress toward achievement of desired outcomes; identify continuing need for home care; meet the medical, nursing, rehabilitative, social, and discharge planning needs; incorporate the current version of the OASIS items; include a review of all medications; and be completed by the appropriate discipline. If the assessment does not meet the required standards, the paid claim will be disallowed.	42 CFR Section 484.55 42 CFR Section 484.55(b)(1) 42 CFR Section 484.55(b)(2) 42 CFR Section 484.55(b)(3) 42 CFR Section 484.55(c) 42 CFR Section 484.55(e) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix III
Services – Failure to update the comprehensive assessment	The record, pertinent to the date of service, will be reviewed to determine if the applicable assessment was performed. The comprehensive assessment must be updated and revised (including the OASIS instrument) as frequently as the patient's condition warrants. If the comprehensive assessment has not been updated as required, the paid claim will be disallowed.	42 CFR Section 484.55(d)(1)(i)-(iii) 42 CFR Section 484.55(d)(2)&(3) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual
Services – POC does not adequately address patient needs	The POC and record, pertinent to the date of service, will be reviewed to determine if the POC addresses the patient's current health and safety needs. If the POC fails to address the patient's current health and safety needs, the paid claim will be disallowed.	42 CFR Section 484.18 42 CFR Section 484.18(a) 42 CFR Section 484.18(c) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual
Services – Failure to review/update the POC	The POC and record, pertinent to the date of service, will be reviewed to determine if the POC was reviewed/updated as required by the regulations. The POC must be reviewed and updated as frequently as the patient's condition warrants but no less than every 62 days. The record must contain written documentation that the authorized practitioner was notified of any significant changes that may require an update to the POC. If the provider failed to review/update the POC when required, the paid claim will be disallowed.	42 CFR Section 484.30(a) 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) 42 CFR Section 484.14(g) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual

Services – Failure to provide services as required by the POC /medical order	If the record shows the services billed by the provider are not consistent with the ordered services or POC, the difference between the paid claim and the services ordered will be disallowed.	42 CFR Section 484.18 42 CFR Section 484.18(c) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual
Services – Home health aide services not provided in accordance with POC	Payment will be disallowed for home health aide services if they are not included in a written care plan for home health aide services completed by a registered nurse supervisor.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400
Services – Supervision visit not performed within required timeframe	If the required home health aide supervision visit was not documented within the required time period, the paid claim will be disallowed. If the patient is receiving skilled services, the RN (or appropriate therapist if the only skilled service is OT, PT, or ST) must make an onsite visit to the patient's home at least once every two weeks. The home health aide does not need to be present at the time of the onsite visit. If the onsite visit has not occurred within the two weeks prior to the date of service, the paid claim will be disallowed. If the patient is not authorized to receive skilled services, the RN must make a supervisory visit every 60 days while the home health aide is providing patient care. If the supervisory visit has not occurred within the 60 days prior to the date of services, the paid claim will be disallowed.	42 CFR Section 484.36(d)(1)&(2) 42 CFR Section 484.36(d)(3) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Services – Failure to meet the standards of supervision	The record, pertinent to the date of service, will be reviewed to determine if the provider met the standards for home health aide supervision as required by the regulations. If the provider failed to meet the required standards of supervision, the paid claim will be disallowed.	42 CFR Section 484.36(c) 42 CFR Section 484.36(d)(1)&(2) 42 CFR Section 484.36(d)(3) 42 CFR Section 484.30(a) KMAP Provider Agreement
Services – Improper assessment for home health services	Payment will be disallowed for the 60-day assessment service if the RN did not perform the assessment while providing a skilled service during the supervisory visit.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix III
Services – Hands-on care	Payment will be disallowed for services provided by the home health aide that are not for hands-on care or an Instrumental Activity of Daily Living in conjunction with hands-on care or that are provided outside of the beneficiary's home.	42 CFR Section 484.36(c)(2) KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Services – Concurrent home health services	Payment for services will be disallowed if the beneficiary is receiving the same home health service concurrently from an individual therapist, clinic, hospital, practitioner, rehabilitation center, or other health care provider. All services on the POC must not duplicate other services.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Services – Noncovered services	Payment will be disallowed for services if the paid service is not covered under the Medicaid program.	KAR 30-5-59(e)(1) "Accept as payment in full, subject to audit when applicable, the amount paid by the Medicaid/ MediKan program for covered services" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Home Health Agency FFS Provider Manual, Section 8400, Appendix I and III

KMAP Home Health Agency Protocols

Services – Exceeding POC limits	Payment will be disallowed for services that exceed or are not included in the beneficiary's care plan signed by the physician.	KAR 30-5-70(c)(1)(L) "The service exceeds the limitation defined by the program policies" KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Services – Not rendered	Payment will be disallowed for services that have not been rendered. For example, KMAP will disallow home health aide services to a beneficiary while the beneficiary is in the hospital.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Section 8400 and Appendix III
Limitation – Prior authorization	Payment will be disallowed for services if prior authorization is required and the provider did not comply with the prior authorization requirements.	KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual, Appendix II and III
Limitation – Services not provided by an approved health provider	Payment will be disallowed for services if the home health service was not provided by an individual who is properly licensed or certified to perform the service.	KSA 65-2803 KSA 64-2913 KSA 65-5414 KSA 65-6504 KSA 65-5115 KSA 65-1115 – Kansas Nurse Practice Act KSA 65-1116 – Kansas Nurse Practice Act KAR 30-5-70(c)(1)(K) "The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the Medicaid/MediKan program" KMAP Provider Agreement KMAP Home Health Agency FFS Provider Manual
Excluded provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 "Provider participation requirements" KAR 30-5-67 "Disallowance of claims for services generated by providers ineligible for participation" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement
Unmet program requirements for Ordering, Referring, Attending, Prescribing, and Sponsoring providers	Effective April 1, 2019, all physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid beneficiaries (or other professionals who provide services under the state plan) are required to enroll with KMAP.	42 CFR 455.410 42 CFR 455.440 KMAP General Benefits FFS Provider Manual, Section 2000

KMAP Physician Services Protocols

Finding	Criteria	Regulatory References
Billing – After beneficiary's death	Claims must be submitted only for payment of services actually furnished and medically necessary. Payment will be disallowed if the claim is for a date of service after the beneficiary's death.	KAR 30-5-70 "Payment for medical expenses for eligible recipients" KAR 30-5-63 "Medical necessity" KMAP Provider Agreement KMAP General Billing FFS Provider Manual, Section 5600
Billing – Cancelled visits or appointments not kept	Payment will be disallowed for a "no show" or cancelled visit.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 7010
Billing – Beneficiary pays for covered services	Unless the provider refunds the beneficiary's payment, KMAP payment will be disallowed for a covered service if a provider requests payment from a beneficiary over and above the amount received as payment in full by KMAP.	KAR 30-5-59(e)(3),(4),(5) "Payment. Each participating provider shall meet the following conditions:" KMAP Provider Agreement
Billing – Duplicate services	If the provider has billed separately for a service that is included in the reimbursement for that or another paid service; OR if the provider billed for a service that is part of the follow-up care for that or another paid service; OR if the provider billed for a service which was previously paid to that provider or a related provider, the service will not be covered. Concurrent services and skills of two or more persons may be paid if necessary because of the beneficiary's medical condition.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 Nursing/Intermediate Care Facility FFS Provider Manual, Section 7040
Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payer.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Billing – Incorrect procedure code	If the provider has billed an incorrect procedure code, payment will be disallowed.	Current Procedure Terminology (*CPT*®) codebook KMAP Provider Agreement KMAP Professional FFS Provider Manual
Billing – Lack of documentation	Payment for a time-based code will be disallowed if the provider fails to document the length of the encounter.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Payment limitations	Any excess payment will be disallowed for a service if the payment exceeds the fee contained in the physician fee schedule, exceeds the usual and customary charge to the public, or exceeds the amount billed by the provider.	KMAP Provider Agreement KMAP Fee Schedule
Enrollment – Performing physician not licensed	Payment will be disallowed if the provider performing the service for which the claim is made is not licensed in Kansas at the time the service was performed.	KAR 30-5-59 "Provider participation requirements" KAR 30-5-70(c)(1)(K) "The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the Medicaid/MediKan program" KMAP Provider Agreement
Enrollment – Unenrolled provider in group practice	Payment will be disallowed for services rendered by a physician or physician assistant who is not enrolled in the provider's practice, unless the provider was granted a retroactive enrollment effective date by specific written approval from the Medicaid agency.	42 USC § 1396a(a)(27) 42 CFR Section 431.107 KMAP Provider Agreement KMAP General Introduction FFS Provider Manual, Introduction

KMAP Physician Services Protocols

Limitation – Anesthesia services	If the paid service is not billed in accordance with the anesthesia reimbursement guidelines, payment of the difference between the paid amount and the amount allowed will be disallowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 7010
Limitation – Billed by MD, performed by APRN or PA	If KMAP pays for a service billed by a physician or physician group but the service was actually performed by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA), the amount paid in excess of the allowed amount for an APRN or PA will be disallowed. Having the physician sign off on the medical record that was prepared by the APRN or PA is not acceptable on its own to be paid at the physician rate. The physician himself or herself needs to perform the services and document the services that were performed by him or her in order for the services to be paid at the physician rate.	KSA 65-28a02 “Physician Assistants” KAR 100-28a-6 “Scope of Practice” KAR 100-28a-12 “Designated Physician” KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 7010
Limitation – Performed by an APRN or PA outside of the scope of a delegated/ collaborative agreement	Payment will be disallowed if the paid service was performed by an APRN or PA and is outside of the signed delegated service/collaborative agreement, if applicable, with the supervising physician.	KSA 65-28a02 “Physician Assistants” KAR 100-28a-6 “Scope of Practice” KAR 100-28a-12 “Designated Physician” KAR 60-11-101, Advanced Practice Registered Nurses (APRN), “Definition of expanded role; limitations; restrictions” KMAP Provider Agreement
Limitation – Performed by an APRN or PA without a delegated/collaborative agreement	Payment will be disallowed for service if the paid service was performed by an APRN or PA and there is not a delegated service agreement or collaborative agreement in place with a supervising physician, if applicable.	KSA 65-28a02 “Physician Assistants” KAR 100-28a-6 “Scope of Practice” KAR 100-28a-12 “Designated Physician” KAR 60-11-101, Advanced Practice Registered Nurses (APRN), “Definition of expanded role; limitations; restrictions” KMAP Provider Agreement
Limitation – Family planning, abortion, and hysterectomy	If the paid service is not billed in accordance with the family planning, abortion, and hysterectomy reimbursement guidelines (sterilization, hysterectomies, abortions), the payment will be disallowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Sections 8300 and 8400
Limitation – Laboratory services	If the paid service is not billed in accordance with the laboratory reimbursement guidelines (no billing for urinalysis without microscopy, hemoglobin and urine glucose determination in conjunction with an office visit, laboratory physician services the provider is authorized to perform in the provider's office), KMAP will disallow the difference between the amount paid and the amount allowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 8400
Limitation – Newborn care	If the paid service is not billed in accordance with the newborn care reimbursement guidelines (routine care and subsequent hospital care/critical care/newborn resuscitation), KMAP will disallow the difference between the amount paid and the amount allowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section7010

Limitation – Radiology services	If the paid service is not billed in accordance with the radiology reimbursement guidelines (use of appropriate modifier for professional component, technical component if use of equipment only, written documentation to the referring provider), KMAP will disallow the difference between the amount paid and the amount allowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Sections 7010 and 8400
Limitation - Surgical services	If the paid service is not billed in accordance with the surgical reimbursement guidelines (multiple surgery, assistant surgeon, global fee, no related E&M encounters on the date of surgery), KMAP will disallow the difference between the amount paid and the amount allowed.	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 8400
Limitations – Prior authorization	Payment will be disallowed for a service if the paid service is not in conformance with prior authorization requirements prior to payment.	KMAP Provider Agreement KMAP General Special Requirements FFS Provider Manual, Section 4300
Medical Record – Cloning documentation	Payment will be disallowed if the documentation for services rendered is the result of identical or similar entries from copying/pasting ("cloning"), which misrepresents the medical necessity required for the rendered service and/or does not reflect updated clinical information, including physical exams and assessments.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Incorrect procedure code	If the medical record does not support circumstances consistent with the procedure code that was billed, KMAP will disallow the difference between the paid code and the correct code.	Social Security Act Section 1902(a)(27)(A),(B) *CPT codebook* KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Medical necessity	Payment will be disallowed for the service without evidence and documentation in the medical record that a paid service was medically necessary.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-63 Medical necessity KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Insufficient documentation of services billed	Payment will be disallowed for undocumented services: (1) if there are not notes in the medical record to support that the service was rendered or that appropriate units were billed; or (2) there is no physical evidence of the service, such as an x-ray film. If the x-ray needed to support a paid service is not available, KMAP will disallow any amount paid for services that were dependent on that image to substantiate the services rendered.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 8400 KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – No documentation of service	Payment will be disallowed for service if documentation of the service is not available for audit.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 8400 KMAP General Benefits FFS Provider Manual, Section 2700

KMAP Physician Services Protocols

Medical Record – No written order or excess of order	If the paid service was not ordered by a physician (services include, but are not limited to, consultations) or was paid in excess of a physician's order (ancillary services which include, but are not limited to, lab work, x-rays, therapy, administration of medications/vaccines, diagnostic testing), KMAP will disallow the difference between the paid services and the services actually ordered.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Resident	If the medical record fails to document the service was performed by a medical resident while the attending physician was physically present during the critical or key components of the service and the attending physician does not personally document the history of present illness, the physical examination, and medical decision-making activities, payment will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Manual, Section 2700 CMS factsheet “Guidelines for Teaching Physicians, Interns, and Residents”
Medical Record – Signature	Payment will be disallowed for a service if the paid service was based on medical records that are not signed by the performing physician, if a rubber stamp was used as the physician signature, or if an electronic signature on an electronic health record does not comply with the requirements of the Electronic Signature policy.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Services – Limitations for all beneficiaries	Payment will be disallowed for a service if the paid service exceeds the limitations of the Medicaid program.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2000
Services – Noncovered services for all beneficiaries	Payment will be disallowed for a service if the paid service is not covered under the Medicaid program.	KAR 30-5-59(c)(4) “submit claims only for covered services provided to consumers” KMAP Provider Agreement
Services – Provider is not assigned as the lock-in provider	Payment will be disallowed if the provider performing the service is not designated as the lock-in provider.	KAR 30-5-70(c)(1)(H) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2400
Services – Provider's facility	Payment will be disallowed if the paid service was provided by a provider where the hospital was also paid a professional component (or is generally reimbursed for a professional component for the relevant category of service).	KMAP Provider Agreement KMAP Professional FFS Provider Manual, Section 7010
Services – Resident	Payment will be disallowed if the paid service is performed by a resident or intern without the personal supervision of a physician.	CMS factsheet “Guidelines for Teaching Physicians, Interns, and Residents” KMAP Provider Agreement
Excluded Provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 “Provider participation requirements” KAR 30-5-67 “Disallowance of claims for services generated by providers ineligible for participation” KAR 30-5-70 “Payment for medical expenses for eligible recipients” KMAP Provider Agreement

Unmet program requirements for Ordering, Referring, Attending, Prescribing, and Sponsoring providers	Effective April 1, 2019, all physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid beneficiaries (or other professionals who provide services under the state plan) are required to enroll with KMAP.	42 CFR 455.410 42 CFR 455.440 KMAP General Benefits FFS Provider Manual, Section 2000

KMAP Dental Protocols

Finding	Criteria	Regulatory References
Billing – After beneficiary's death	Claims must be submitted only for payment of services actually furnished and medically necessary. Payment will be disallowed if the claim is for a date of service after the beneficiary's death.	KAR 30-5-70 "Payment for medical expenses for eligible recipients" KAR 30-5-63 "Medical necessity" KMAP Provider Agreement KMAP General Billing FFS Provider Manual, Section 5600
Billing – Buccal and facial surface	Payment will be disallowed for a restoration on the same tooth for both buccal and facial surfaces.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Restorations) ***Note:*** Surfaces should be billed as defined in the current *CDT* manual.
Billing – Cancelled visits or appointments not kept	Payment will be disallowed for a "no show" or cancelled visit.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Dental Provider Manual, Section IV
Billing – Beneficiary pays for covered services	Unless the provider refunds the beneficiary's payment, KMAP payment will be disallowed for a covered service if a provider requests payment from a beneficiary over and above the amount received as payment in full by KMAP.	KMAP Provider Agreement KMAP Dental Provider Manual, Section IV
Billing – Duplicate services	If the provider has billed separately for a service that is included in the reimbursement for that or another paid service; OR if the provider billed for a service that is part of the follow-up care for that or another paid service; OR if the provider billed for a service which was previously paid to that provider or a related provider, a second payment will be disallowed for that service, unless it can be shown that payment for the first service should not have been made.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payer.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Billing – Incorrect procedure code	Payment will be disallowed if a provider used an incorrect procedure code.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Service not in conformance with prior authorization requirements	Payment will be disallowed if a paid service is not in conformance with prior authorization requirements.	KMAP Provider Agreement KMAP Dental Provider Manual, Section V
Billing – Limited exam	Payment will be disallowed for a service if a provider bills using procedure code D0140 (limited exam) in conjunction with any other exam or consultation code including, but not limited to, D9110, D9310, and D9430, or follow-up care.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Clinical Oral Evaluations)
Billing – Payment limitations (maximum fee exceeded)	Payment that exceeds the Medicaid payment limitations will be disallowed.	KMAP Provider Agreement KMAP Dental Provider Manual, Section I
Billing – Anesthesia not billed correctly	The amount paid for the service will be disallowed if the anesthesia was not calculated or billed correctly.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Anesthesia)

KMAP Dental Protocols

Enrollment – Performing dentist not licensed	Payment will be disallowed for services by a dentist who is not licensed at the time the services were performed, except for students enrolled in an accredited dental school and residents in accredited dental programs.	KAR 30-5-59 "Provider participation requirements" KMAP Provider Agreement
Limitation – Complete intraoral series	Any payment will be disallowed for procedure code D0210 that is more than the payment would be if individual films were taken and billed. If images are billed under procedure code D0210 but there are not at least 10 periapicals and up to four bitewings and the crowns and roots of all teeth, periapical areas, and alveolar bone are not displayed, the payment will be the amount allowed for a complete intraoral series or the amount of the films billed separately, whichever is less.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Radiographs)
Limitation – Filling to same tooth by the provider	Except as documented for extenuating circumstances, payment will be disallowed to a provider for a filling to a tooth if the same provider filled the same tooth within a year.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Restorations)
Limitation – First periapical film	For procedure code D0220, providers should bill the first periapical image as D0220 and the additional periapicals with D0230. One D0220 will be allowed per date of service, per beneficiary, per provider or provider group.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Radiographs)
Limitation – Sealants	Payment will be disallowed if sealants are provided beyond limitations. Sealants are reimbursable once per 12 months per tooth, when placed on the occlusal or occlusal-buccal surfaces of lower 1st and 2nd permanent molars or upper 1st and 2nd permanent molars as well as permanent upper and lower bicuspids. Teeth must be caries free. Sealant is not covered when placed over restorations.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Other Preventative Services)
Limitations – Prior authorization requirements	Payment will be disallowed if a provider does not conform to prior authorization requirements when prior authorization is required, as specified in regulations or policy bulletins.	KMAP Provider Agreement KMAP Dental Provider Manual, Section V
Limitations – Alveoloplasty	A claim for an alveoplasty on the same day and in the same quadrant as a claim for an extraction will be disallowed.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits (Oral Surgery)
Medical Record – Anesthesia	Payment will be disallowed for anesthesia (IV-sedation or general) that is not supported by proper documentation. KMAP pays for anesthesia from the time the medication is placed in the IV to the time the infusion of the anesthetic agent stops, in 15-minute intervals. The exact start and stop times, as well as the name and dosage of the pharmaceutical agents used and monitoring of vital signs, must be documented in the chart.	Social Security Act Section 1902(a)(27)(A),(B) ADA *CDT Manual*, Anesthesia codes 2015 KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Dental Provider Manual, Section X and Exhibits (Anesthesia)
Medical Record – Bitewings	Payment will be disallowed for bitewings that do not significantly differ from each other and do not provide additional diagnostic information. For example, if 2 bitewings are adequate to show the status of the teeth and the provider takes 2 additional bitewings that do not contribute any further diagnostic value, the 2 additional bitewings will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700

KMAP Dental Protocols

Medical Record – Diagnostic imaging	Payment will be disallowed for images which are not clear and fail to be of diagnostic quality. In addition, payment will be disallowed for any services that were dependent on that image to substantiate that service.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Diagnostic imaging	Payment will be disallowed for periapical X-rays unless the medical record documents the medical necessity for taking the periapical X-ray of the specific tooth or the periapical region including the periodontal ligament area of the tooth.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Evaluations	Payment will be disallowed for any evaluation not performed by a licensed dentist and documented as such in the medical record.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Medical necessity	Payment will be disallowed for the service without evidence and documentation in the dental record that a paid service was medically necessary.	Social Security Act Section 1902(a)(27)(A),(B) KAR 30-5-63 Medical necessity KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Dental Provider Manual, Section V
Medical Record – Missing, inadequate, incorrect, or insufficient documentation of services billed	Payment will be disallowed for services including but not limited to: • An entire dental record is missing or there is not any information in the dental chart. • There are not any notes indicating that services were rendered including why they were rendered. • The provider has incorrect, inadequate, or illegible supporting documentation for a service provided. • If physical evidence is not present, such as an image, intraoral photograph, or lab report. If the provider cannot produce an image that is necessary to support a paid service, KMAP will disallow that portion of the paid service that was dependent on the image to substantiate the service.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Not signed by the performing dentist	Payment will be disallowed for a service if the performing dentist fails to sign his or her notes with a signature or initials in the dental records each time an entry is made.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Medical Record – Surgical extractions	If documentation of the paid service does not support the circumstances for the surgical procedure code billed, KMAP will adjust the amount of the paid service to the documented service and disallow the difference in payment. The description included in the ADA Code of Dental Terminology (CDT) should be used as a guide for documenting the extraction in the dental record. For example, to bill procedure code D7210, the dental record could state "removed erupted tooth requiring removal of bone and elevation of mucoperiosteal flap" if this appropriately describes the service that was performed.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700

KMAP Dental Protocols

Documentation – Missing, inadequate, or incorrect dental forms	If any required dental form submitted by a provider for reimbursement is missing, inadequate, or incorrect the amount paid for the service will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Missing, incomplete, or incorrect information on dental form	If any required dental form information submitted by a provider for reimbursement is missing, incomplete, incorrect, or illegible, the amount paid for the service will be disallowed.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Services – Limitations	Payment will be disallowed for services exceeding the limitations for covered services set forth in regulations, statutes, or policy bulletins.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits
Services – Dental treatment/service provider is not a covered or essential service	If the paid treatment/service is beyond the scope of the KMAP dental program and is not a covered or essential service, the amount paid will be disallowed.	KMAP Provider Agreement KMAP Dental Provider Manual, Exhibits
Excluded provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 “Provider participation requirements” KAR 30-5-67 “Disallowance of claims for services generated by providers ineligible for participation” KAR 30-5-70 “Payment for medical expenses for eligible recipients” KMAP Provider Agreement
Unmet program requirements for Ordering, Referring, Attending, Prescribing, and Sponsoring providers	Effective April 1, 2019, all physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid beneficiaries (or other professionals who provide services under the state plan) are required to enroll with KMAP.	42 CFR 455.410 42 CFR 455.440 KMAP General Benefits FFS Provider Manual, Section 2000

KMAP Pharmacy Protocols

Finding	Criteria	Regulatory References
Billing – After beneficiary's death	Claims must be submitted only for payment of services actually furnished and which are medically necessary. Payment will be disallowed if the claim is for a date of service after the beneficiary's death.	KAR 30-5-70 Payment of medical expenses for eligible recipients KAR 30-5-63 Medical necessity KMAP Provider Agreement
Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payer.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Billing – Prescriber NPI on prescription does not match claim	Payment will be disallowed if the prescriber's NPI on the prescription does not match the claim.	KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 7010
Billing – Quantity dispensed does not match quantity on claim	KMAP will disallow the difference between the quantity paid and the quantity actually dispensed if the quantity dispensed does not match the quantity billed on the claim.	KMAP Provider Agreement KMAP General Benefits Provider Manual, Section 2700 Pharmacy Claim instructions under Metric Quantity (Field 12) for paper claims and Quantity Dispensed in the NCPDPD Companion Guide
Billing – Partial fill	Payment will be disallowed if requirements for partial fills are not met.	K.S.A 68-20-19(c) and 68-20-20(c) "Partial filling of prescriptions" KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400
Documentation – Diagnosis code	Payment will be disallowed if the diagnosis code submitted on a claim is not on the prescription.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400
Documentation – Directions do not match prescription SIG	Payment will be disallowed if the directions on the prescription record concerning dosage and frequency do not match the directions on the original prescription.	Social Security Act Section 1902(a)(27)(A),(B) KSA 65-1637 "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Information missing from prescription/order	Payment will be disallowed if the prescription/order is missing required information including but not limited to: • Missing member name • Missing name of item/drug • Missing strength (if applicable) ***Note:*** For telephone orders, payment is disallowed when the prescriber name or any of the above items is not present on either the prescription document or the attached label.	Social Security Act Section 1902(a)(27)(A),(B) KSA 65-1637 "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – DEA number on controlled substance prescription	If an official prescription prepared by a practitioner for a controlled substance does not have the prescriber's DEA number, the paid claim will be disallowed. The pharmacist can add the DEA number to the prescription upon oral authorization by the practitioner. This authorization must be noted by the pharmacist on the prescription and indicate the date the authorization was received and include the pharmacist's signature.	Social Security Act Section 1902(a)(27)(A),(B) March 2014 Kansas State Board of Pharmacy Newsletter on the Kansas Board of Pharmacy website KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Pharmacy FFS Provider Manual, Section 8400

KMAP Pharmacy Protocols

Documentation – Prescriber signature missing or invalid	Payment will be disallowed if the prescriber signature is missing or invalid on the prescription. Examples of invalid signatures include, but are not limited to, electronic signatures on prescriptions for controlled substances converted to a facsimile.	Social Security Act Section 1902(a)(27)(A),(B) DEA Rule "Electronic Prescriptions for Controlled Substances" on the DEA website Kansas Pharmacy Act, Uniform Controlled Substances Act-Electronic Prescription Amendments (Senate Bill 134) on the Kansas Board of Pharmacy website KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Prescription missing	Payment will be disallowed if the prescription is missing from the pharmacy files or does not cover the date of service of the claim.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Pharmacy FFS Provider Manual, Section 8400
Documentation – Refills exceeded	Payment will be disallowed if the number of refills or total prescribed quantity have been exceeded.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP Pharmacy FFS Provider Manual, Section 8400
Documentation – Tamper resistant	Payment will be disallowed if the prescription does not meet tamper resistance requirements.	Social Security Act Section 1902(a)(27)(A),(B) Social Security Act Section 1903(i)(23) 42 U.S.C. Sec. 1396b(i)(23) KMAP Provider Agreement KMAP General Benefits Manual, section 2700. KMAP Pharmacy Provider Manual, section 8400, "Tamper-Resistant Prescriptions".
Documentation – Invalid prescription/order	The paid claim is disallowed when a prescription/order is invalid. An invalid prescription/order is not in compliance with the Kansas Pharmacy Act and other related laws and shall include, but is not limited to, the following: • Postdated prescriptions/orders (ordered after the original date of service) • Prescriptions/orders billed for a different patient than ordered • Scheduled prescriptions not ordered, dispensed, or cancelled as required • Transferred prescriptions failing to meet minimum program and regulatory requirements	Social Security Act Section 1902(a)(27)(A),(B). 21 CFR 1306.25 "Transfer between pharmacies of prescription information for Schedules III, IV, and V controlled substances for refill purposes" KSA 65-1637 "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" KSA 65-1656 "Filling transferred prescriptions; exceptions and conditions; common electronic prescription files authorized; rules and regulations" KAR 68-20-18 "Information concerning prescriptions" Kansas Pharmacy Act on the Kansas Board of Pharmacy website DEA Pharmacist Manual, Section IX & Section X, on the DEA website KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700

KMAP Pharmacy Protocols

Services – Prescription filled greater than six months from the date written (for CIII-V)	Payment will be disallowed if documentation demonstrates a prescription for CIII-V was billed in excess of five refills within six months from the date the prescription was written.	KSA 65-1637 "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" Uniform Controlled Substances Act-Electronic Prescription Amendments (Senate Bill 134) June 2012 Kansas State Board of Pharmacy Newsletter on the Kansas Board of Pharmacy website KMAP Provider Agreement
Services – Prescription filled greater than 12 months from the date written for noncontrolled drugs	Payment will be disallowed if documentation demonstrates a prescription was billed beyond 12 months from the date the prescription was written.	KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400
Services – Pharmacy billed in excess of prescribed quantity	If the pharmacy is paid for a claim where the quantity of the item exceeds the amount ordered on the prescription, the difference between the cost of the quantity dispensed and the cost of the quantity ordered will be disallowed. • The quantity ordered is either specified on the prescription/order or results from a calculation of ordered directions/ordered days supply/patient weight. • For nonprescription drug orders, if the ordering prescriber does not request a quantity that corresponds to the prepackaged unit, payment will not be disallowed when the pharmacist supplies the nonprescription drug in the prepackaged quantity that most closely approximates the amount ordered.	KSA 65-1637 "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400
Services – Pharmacy billed for different strength/different drug than ordered	If the pharmacy is paid for a claim where the strength of an item is different than the strength ordered on the prescription/order, the paid claim is disallowed. Exceptions include: • For controlled drugs, the pharmacist may adjust the strength only with prescriber authorization. The pharmacist shall write on the prescription the time and date the authorization was received, the reason for the change, and his/her initials or signature. • For noncontrolled drugs, the pharmacist may have reason to adjust the strength due to product availability or appropriate patient request (such as inability to swallow strength/form prescribed). The pharmacist shall document with his or her initials the time and date the prescriber or prescriber's agent was contacted.	DEA Pharmacist Manual, Section IX & Section X, on the DEA website March 2014 Kansas State Board of Pharmacy Newsletter on the Kansas Board of Pharmacy website KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400

KMAP Pharmacy Protocols

Services - Return & crediting of unused medications	Long-term care facilities are required to return unused medications to the pharmacy for repackaging and reimbursement to the Kansas Medicaid Agency if the drug product is not a controlled substance, is individually sealed, is returned within 90 days before expiration, and is of acceptable integrity. The quantity actually received by the beneficiary will be allowed. Payments for medications returned to the pharmacy (or which should have been returned per K.A.R 30-5-92) will be disallowed.	KAR 30-5-92 "Scope of Pharmacy Services" KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 7010
Services – ProDUR auto deny alerts	DUR alerts that will auto deny include refill too soon, pregnancy alert, and therapeutic duplication. Payment will be disallowed when documentation does not support that the service meets an exception if an override code is used.	Omnibus Budget Reconciliation Act of 1990 (OBRA-90) KMAP Provider Agreement KMAP Pharmacy FFS Provider Manual, Section 8400
Services – Pharmacy indicated date dispensed after prescribing provider's death date	A pharmacist may refill a prescription order except a schedule II controlled substance without the prescriber's authorization when all reasonable efforts to contact the prescriber have failed and when (in the pharmacist's professional judgment) continuation of the medication is necessary for the patient's health, safety, and welfare.	KSA 65-1637(b) "Pharmacist required to be in charge of pharmacy; compounding, filling, and refilling of prescriptions; refusal to fill; brand exchange" KMAP Provider Agreement
Services – Provider is not assigned as the lock-in provider	Payment will be disallowed if the provider performing the service is not designated as the lock-in provider.	KAR 30-5-70(c)(1)(H) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2400
Excluded provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 "Provider participation requirements" KAR 30-5-67 "Disallowance of claims for services generated by providers ineligible for participation" KAR 30-5-70 "Payment for medical expenses for eligible recipients" KMAP Provider Agreement
Unmet program requirements for Ordering, Referring, Attending, Prescribing, and Sponsoring providers	Effective April 1, 2019, all physicians and other eligible practitioners who order, refer, or prescribe items or services to Kansas Medicaid beneficiaries (or other professionals who provide services under the state plan) are required to enroll with KMAP.	42 CFR 455.410 42 CFR 455.440 KMAP General Benefits FFS Provider Manual, Section 2000

KMAP DME Protocols

Finding	Criteria	Regulatory References
Documentation – Required documentation not available for review	Payment will be disallowed if documentation is missing. Per KSA 21-5931(c) and the KMAP Provider Agreement, required documentation must be maintained for five years.	Social Security Act Section 1902(a)(27)(A),(B) KSA 21-5931 "Destruction or concealment of records" KAR 30-5-59 "Provider Participation requirements" KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – Missing prescription	Payment will be disallowed if the prescription or Certificate of Medical Necessity (CMN) is missing.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Documentation – Incomplete prescription	Payment will be disallowed if the prescription or CMN does not contain all the required information.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Documentation – Prescription not signed	Payment will be disallowed if the prescription is not signed by a licensed practitioner authorized to issue the prescription within the practitioner's scope of practice.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME Provider Manual, Section 8400
Documentation – CMS for oxygen services	Payment will be disallowed if the CMN does not cover the date of service. Recertification CMN is required 12 months after the initial certification and every 12 months following for all beneficiaries. For short-term acute conditions, an initial certification is required and recertification is required every three months following until oxygen is discontinued.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Documentation – CMS-484 CMN-Oxygen form not used	For a beneficiary with acute, short-term conditions (for example, bronchitis or pneumonia) a new qualifying laboratory value and a new physician's order must be obtained prior to initiation of oxygen and every three months following. A Certificate of Medical Necessity – Oxygen form which has been completed in its entirety, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. All providers must use the CMS-484 form. This form must be completed in its entirety according to the CMS instructions and be in the beneficiary's file at all times. According to CMS instructions, Section B of this form cannot be completed by the DME supplier. A new, updated form must be completed each time a beneficiary's oxygen needs changed. This is done every 12 months. This form must be updated no less than every 12 months.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410

KMAP DME Protocols

Documentation – Medical Evaluation and Audiometric report missing	Payment will be disallowed if the Medical Evaluation or Audiometric report is missing.	Social Security Act Section 1902(a)(27)(A),(B) KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Documentation – No delivery receipt	Payment will be disallowed if the delivery receipt is missing.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Documentation – Delivery receipt is not complete	Payment will be disallowed if the delivery receipt does not contain all the required information.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Documentation – Delivery receipt is not signed	Payment will be disallowed if the delivery receipt is not signed documenting the beneficiary took delivery of the item.	Social Security Act Section 1902(a)(27)(A),(B). KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Billing – Excess of quantity ordered	Payment for the difference between the quantity of the paid claim and the quantity that was ordered will be disallowed when the claim is in excess of what was ordered.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Billing – Excess of allowable refills	The maximum number of refills permitted for medical/surgical supplies is in the fee schedule. The number of refills must not exceed the number on the prescription or order. Payment will be disallowed if the paid claim is not covered by the number of refills on the prescription or order.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Oxygen services	Payment for the amount exceeding the maximum will be disallowed.	KMAP Provider Agreement KMAP Fee Schedule on the KMAP website
Billing – Item paid does not match item ordered	Payment will be disallowed for an item if that item was not ordered (wrong product).	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Duplicate payment	Duplicate payments will be disallowed.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Billing – Failure to use third-party liability	Payment will be disallowed for the service if the provider failed to first use the beneficiary's private/other insurance/third-party payer.	42 CFR 433.139(b) "Probable liability is established at the time the claim is filed" KAR 30-5-70(c)(1) "Payment for medical expenses for eligible recipients" KMAP Provider Agreement KMAP General TPL Payment FFS Provider Manual, Section 3100
Billing – Incorrect amount billed/paid	To verify services provided in the course of a postpayment review, providers shall retain in their files the prescription signed by the physician.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700 KMAP DME FFS Provider Manual, Section 8410
Billing – Content of service	Payment will be disallowed for items provided by a facility or organization when the costs of the items are included in the rate (e.g. nursing home/facility). If the item is included in the facility's Medicaid rate then the dispensing provider should bill the facility.	KMAP Provider Agreement KMAP DME FFS Provider Manual, Sections 8410 and 8420

KMAP DME Protocols

Billing – After beneficiary's death	Claims must be submitted only for payment of services actually furnished and medically necessary. Payment will be disallowed if the claim is for a date of service after the beneficiary's death and does not relate to the customer equipment exception.	KAR 30-5-70 "Payment of medical expenses for eligible recipients" KAR 30-5-63 "Medical necessity" KMAP Provider Agreement
Limitations – Incorrect procedure code	The difference between payment of the incorrect procedure code and correct procedure will be disallowed if payment is under an incorrect procedure code.	KMAP Provider Agreement KMAP General Benefits FFS Provider Manual, Section 2700
Limitations – DME billed in excess of pricing rules	Covered DME items are usually priced according to the pricing on the fee schedule. However, there are some DME items that are priced according to manual pricing rules which may vary according to the product. For example, wheelchair accessories that are covered and not on the fee schedule are priced at 75% or the MSRP. Manually priced mounting systems and accessories for augmentative communication/speech generating devices will be reimbursed at 80% of MSRP. The general manual pricing rules are as follows. KMAP requires providers to follow current policy for DME and P&O. Current policy requires DME and P&O to be priced at the lesser of 1, 2, or 3: 1. Set Medicaid rate 2. Providers cost plus 35% 3. MSRP minus 20%	KMAP Provider Agreement KMAP DME FFS Provider Manual, Section 8400
Limitations – Billed in excess of the maximum allowance	Payment exceeding the maximum will be disallowed if the paid claim exceeds the maximum allowance per the fee schedule.	KMAP Provider Agreement KMAP Fee Schedule on the KMAP website
Limitations – Quantity dispensed exceeds maximum allowances	Payment will be disallowed for a quantity exceeding the maximum allowed on the Medicaid fee schedule, without prior authorization.	KMAP Provider Agreement KMAP DME FFS Provider Manual, Sections 8410 and 8420
Services – Labor charges	Payment will be disallowed for those charges that are part of the procedure code included in the fee schedule. The charges that are part of the procedure code include, but are not limited to, labor charges, fittings, and delivery costs.	KMAP Provider Agreement KMAP DME FFS Provider Manual, Section 8410 ***Note:*** All maintenance and repairs of rented systems are considered content of service and cannot be billed separately. Maintenance and repairs of purchased DME requires PA.
Services – Improper services dispensed	Payment will be disallowed if a provider dispenses products or services for which the provider is not properly enrolled.	KMAP Provider Agreement KMAP General Special Requirements FFS Provider Manual, Section 4300 KMAP DME FFS Provider Manual, Section 8400
Services – Unqualified ordering practitioner	Ordering of DME, medical/surgical supplies, orthotic and prosthetic appliances and devices, and orthopaedic footwear is limited to the practitioner's scope of practice. Qualified practitioners are defined as physicians, dentists, podiatrists, physician assistants, and nurse practitioners. Payment will be disallowed if the practitioner signing the prescription/order is not qualified to order the items.	KMAP Provider Agreement KMAP DME FFS Provider Manual, Section 8400 KMAP Prosthetic and Orthotic FFS Provider Manual, Section 8400

Services – Unqualified dispenser	Orthopedic footwear must be dispensed by an employee who has certification from one of the following: the American Board of Certification in Orthotics and Prosthetics, Board for Certification in Pedorthics, or Board for Orthotist Certification. Payment will be disallowed if the item related to the paid claim was dispensed by an unqualified dispenser.	KMAP Provider Agreement KMAP Prosthetic and Orthotic FFS Provider Manual, Section 8400
Excluded provider	Services associated with a provider who has been disbarred by the Office of the Inspector General (OIG) with the U.S. Department of Health and Human Services (HHS) are not covered. This includes services where the disbarred entity is the billing, rendering, ordering, referring, prescribing, attending, or operating provider.	Social Security Act Section 1128(A) KAR 30-5-59 “Provider participation requirements” KAR 30-5-67 “Disallowance of claims for services generated by providers ineligible for participation” KAR 30-5-70 “Payment for medical expenses for eligible recipients” KMAP Provider Agreement
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