Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS Autism

Updated 09.2024

PART II
HCBS AUTISM FEE-FOR-SERVICE PROVIDER MANUAL

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

INTRODUCTION TO THE HCBS AUTISM FEE-FOR-SERVICE PROVIDER MANUAL

Updated 10/17

The purpose of the Kansas Autism waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. The goal of the Autism waiver is to divert children from entering an inpatient psychiatric facility for individuals 21 years of age and younger as provided in 42CFR440.160 by providing parental support and training. Autism waiver services are available to children who have received a diagnosis of an Autism Spectrum Disorder (ASD), including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified, from a licensed Medical Doctor or Ph.D. Psychologist using an approved autism-specific screening tool. Since research has shown that early intensive interventions with ASD children are effective, a child must be between birth and their fifth year upon entering the waiver and be financially eligible for Medicaid. Children must also meet the Level of Care eligibility determination conducted initially and annually by a qualified Functional Eligibility Specialist. The level of care instrument used to determine initial and annual eligibility for the Autism waiver must be the state-approved functional eligibility instrument. The Kansas Autism waiver has a service limit of three years with a one-time, one-year extension possible.

The Kansas Autism waiver provides three distinctive services to members and their families. These are:

- Family Adjustment Counseling
- Parent Support and Training (peer-to-peer)
- Respite Care

This is the provider-specific section of the provider manual. This section (Part II) is designed to provide information specific to providers of the Home and Community Based Services (HCBS) Autism waiver services and is divided into three sections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** section provides instructions on submitting a claim.

The **Benefits and Limitations** section outlines services included for HCBS Autism waiver members and limitations on these services. It also includes qualifications for HCBS Autism waiver providers, documentation required for reimbursement, and expected service outcomes.

The **Appendix** section contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

HIPAA compliance

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

INTRODUCTION TO THE HCBS AUTISM FEE-FOR-SERVICE PROVIDER MANUAL

Updated 10/17

Access to records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. Providers must also supply records to the Department of Health and Human Services upon request.

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

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

KMAP Audit Protocols
The KMAP Audit Protocols are available on the Provider page of the KMAP website under the ***Helpful Information*** heading.

HCBS AUTISM BILLING INSTRUCTIONS

7000. Updated 11/17

Introduction to the CMS 1500 Claim Form

HCBS Autism waiver providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS-1500 claim to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms) heading.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

Submission of Claim

Send completed claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

HCBS AUTISM SPECIFIC BILLING INFORMATION

7010. Updated 10/17

Enter the appropriate code in Field 24D of the CMS 1500 Claim Form. See the Appendix section for an all-inclusive list of HCBS Autism waiver codes.

Time Keeping
Time must be totaled by actual minutes/hours worked. Billing staff may round the total at the end of the billing cycle to the nearest one-half unit. One unit equals 8 through 15 minutes; one-half unit (.5 units) equals up to and including 7 minutes. Providers are responsible to ensure the services were provided prior to submitting claims.

Client Obligation
If an autism specialist has assigned client obligation to a particular provider and informed that provider to collect this portion of the cost of service from the member, the provider does not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Note: Client obligation is assigned only to the HCBS Autism waiver services included on the KMMS plan of care (POC).

One POC a Month
Prior authorizations through the POC process are approved for one month only. Dates of service that span two months must be billed on two separate claims. For 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 POC and cannot overlap. For example, there are two lines on the POC with the following dates of service: July 1-15 and July 16-31. If a provider bills service dates of July 8-16, the claim will deny because the system is trying to read two different lines on the POC. For the first service line, any date that falls between July 1 and 15 will prevent the claim from denying for date of service.

Same Day Service
For certain situations, HCBS waiver services approved on a POC and provided on the same day a member is hospitalized or in a state mental hospital may be allowed. Situations are limited to HCBS waiver services provided on the date of admission, if provided prior to the member being admitted.

7030. HCBS QUALITY ASSURANCE Updated 09/24

HCBS Quality Assurance
Effective August 1, 2024, HCBS Quality Assurance (QA) Policy provides quality assurance oversight for Medicaid 1915(c) HCBS in the State of Kansas. This policy serves as a basis for the State's QA Unit's review of the HCBS Waiver Programs based on HCBS Performance Measures, Program Policies, and Waiver Requirements per waiver type.

Quality Reviews:
KDADS shall conduct quality reviews on Level of Care (LOC) assessments and Managed Care Organization (MCO) records for participants receiving HCBS Programs to determine:

- KanCare Quality Performance Measure Outcomes
  - The Performance Measures are included in all current/approved HCBS waivers.
- KDADS HCBS Waiver Program Requirement Outcomes
  - May include, but are not limited to, State Plan requirements and HCBS waiver requirements.

As a condition of Centers for Medicaid and Medicare Services (CMS) waiver approval of each HCBS waiver program, the State of Kansas shall have and comply with defined and approved Quality Assurance (QA) policies and procedures contained in this policy.

- The following sub-assurances of the State's HCBS waiver shall have defined and approved QA requirements:
  - Administrative Authority.
  - Evaluation/Reevaluation LOC.
  - Qualified Providers;
  - Service Plan;
  - Health and Welfare; and
  - Financial Accountability
- KDADS shall conduct QA checks through staff designated as Quality Management Specialists (QMS).
  - KDADS may conduct QA checks through, but not limited to, any of the following methods and data sources:
    - Level of Care (LOC) Assessor file reviews
    - MCO file reviews
    - Member's survey feedback
    - Provider's Credentialing, Training, and Background Checks
    - Data found in the following systems:
      - Kansas Aging Management Information System (KAMIS)
      - KMMS
      - Medicaid Management Information System (MMIS)
      - Quality Review Tracker (QRT)
      - Kansas Adverse Incident Reporting and Management System (AIRS)

7030. HCBS QUALITY ASSURANCE Updated 09/24

HCBS Quality Assurance continued

Quality Assurance Procedures:

A. KDADS Financial and Information Services Commission (FISC) will select and assign a representative sample of HCBS waiver participants' case files to the QMS Unit for quarterly review.

B. Documentation Required.
   1. Documentation required for each waiver can be found in the **Documentation** section of this bulletin.

C. Authorized Signature
   1. Signatures must be original handwritten, including digital signatures, and dated by the recipient and/or their representative.
      a) A signature on file and/or a signature that converts to a "typed" signature is unacceptable.
      b) If a recipient has a legal guardian, representative, or activated durable power of attorney (DPOA), the legal guardian or DPOA must sign all required document(s).
         i. In the event of representation through a DPOA, supporting documentation showing DPOA activation is required.
         ii. If an electronic signature is used, it must comply with the KDHE KMAP Provider Bulletin Number 782: Electronic Documentation. This policy must be documented to the KDADS HCBS Director, Policy Program Oversight Manager, and QA Manager.
   2. In the event a participant is unable to manually/hand sign their own name due to physical or other limitations, one or more of the following methods may be utilized:
      a) The use of a distinct mark representing the participant's signature;
      b) The use of the participant's signature stamp and/or;
      c) The use of an identified designated signatory.
   3. If a participant utilizes any of the three options in **Quality Assurance Procedures C.2** listed above, documentation supporting the method selected must be uploaded with the QA review.
   4. Each "authorized signature" must be dated.

D. Procedure for conducting quality reviews shall be as follows:
   1. File Reviews:
      a) KDADS shall review documentation uploaded in the Quality Review Tracker (QRT) by the MCOs and/or assessing entities using the established KDADs protocols.
         i. KDADS QMS shall record findings from file reviews in the QRT for the MCO's/assessor's remediation.

E. Record Submission
   1. MCO files are to be uploaded to the QRT database.
   2. LOC assessing entity must upload documents for all HCBS waivers.

Quality Assurance Procedures continued

a) LOC Assessment documentation for all HCBS waivers, unless an exception is granted for a specific waiver, may be found in the KAMIS or QRT.

3. Case file documentation must be:
   a) Properly labeled with document name and the completion date (month and year); and
   b) Documentation must be legible.
4. At the beginning of each upload period, KDADS will send out specific information regarding documentation that must be uploaded for the audit.
5. When documentation is uploaded to QRT, the MCO/assessing entity must mark the upload as "complete."
6. Documentation uploaded after the deadline will not be considered for the quality review.

F. Deadline for Record Submission
   1. Case files for review shall be listed in the QRT for the review period.
      a) KDADS QA Manager shall notify the MCOs and assessing entity of the required upload.
      b) MCOs and the assessing entity shall have 15 calendar days from upload notification to upload the required documentation.

G. An example of the timeline for a Quality Review is outlined in the following chart:

Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessing Entity Samples Posted	MCO/Assessing Entity Upload Period (*15 days)	Review of Data (*60 days)
01/01 – 03/31	04/01 – 04/15	04/16	04/16 – 04/30	05/01 – 07-01
04/01 - 06/30	07/01 – 07/15	07/16	07/16 – 07/31	08/01 – 10/01
07/01 – 09/30	10/01 – 10/15	10/16	10/16 – 10/31	11/01 – 01/01
10/01 – 12/31	01/01 – 01/15	01/16	01/16 – 01/31	02/01 – 04/01

H. Findings and Remediation
   1. Protocol Scoring Options:
      a) "Compliant" documentation is provided and meets compliance requirements.
      b) "Non-compliant" documentation was not provided or was not correct or complete.
         i. Missing Document (Document/documentation not provided for review);
         ii. No Valid Signature and/or Date ("Valid signature" means by the individual and/or representative/guardian or Care Coordinator/Case Manager. Must have both signature and date);
         iii. Incomplete (Form was not completed in its entirety);
         iv. Inaccurate (Scoring or eligibility is not correct, or services listed are not being received as outlined in the Person-Centered Service Plan (PCSP), or the process for developing a PCSP was not followed); or
         v. Timeline not met.
      c) "N/A" when not applicable to the protocol question.
   2. Findings from file reviews will be recorded in QRT.

Quality Assurance Procedures continued:

I. Remediation and Response Process
   1. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
   2. CMS requires states to submit remediation language and a Quality Improvement Plan for any HCBS Performance Measure when the statewide average for a waiver is less than 86%. Therefore, KDADS shall complete data analysis to ensure that each quality assurance or sub-assurance of less than 86% is remediated. Further, CMS also requires the state to remediate any "non-compliant internally" (less than 100%) for a performance measure even though it may not be below the 86% threshold requiring the data analysis:
      a) KDADS shall notify the MCO and assessing entity of quality assurance or sub-assurance below 86% with details of each finding.
      b) KDADS shall notify the provider of each non-compliance with a performance measure.
      c) Upon notification of the remediation requirement for quality assurance sub-assurance, or performance measures, providers must respond within 10 business days with a detailed plan for correction/remediation strategies and a timeline for completion.
      d) KDADS staff shall review the received remediation plan for approval. If a remediation plan is not approved, KDADS shall notify the provider and request that acceptable remediation be resubmitted.
      e) Once a remediation plan is approved with a timeline for compliance, KDADS will monitor for compliance.
   3. KDADS shall immediately forward/report Abuse, Neglect, or Exploitation (ANE) issues to the designated state reporting agency.
   4. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
   5. If QMS finds issues or concerns on a specific case during a review:
      a) The issues or concerns shall be entered in QRT.
      b) The QRT system will send an alert to the HCBS Program Manager for the Program Manager's review. Issues that may cause an alert to the HCBS Program Manager include, but are not limited to, the following:
         i. The participant being served could not be located or no longer resides at the address provided in the case record;
         ii. Case should be reviewed for potential closure;
         iii. Assessment is not current;
         iv. Participant being served stated they would like their Care Coordinator to contact them;
         v. There is a protective service concern;
         vi. Spouse cannot serve as a Personal Care Service Worker or in any other paid capacity without a "Spousal Exception;"
         vii. Activated DPOAs/legal guardians are not allowed to provide any direct services without court documentation approving them to do so;
         viii. The assessor is not on the qualified assessor list.

7030. HCBS QUALITY ASSURANCE Updated 09/24

Quality Assurance Procedures continued

J. Quality reviews of credentialing; background checks; provider's training:
   1. Refer to policies posted on the KDADS website at HCBS Policies.
   2. Credentials such as provider specifications applicable to each HCBS waiver, background checks, and training are to be provided per the direction of KDADS.
   3. Provider qualification audit review process per the direction of KDADS and waiver standards.

Documentation:

A. Forms
   1. All forms and templates will be sent to the appropriate assessing entity or MCO at the beginning of the upload period via secure email. Specific required documentation for the audit will be listed in the following documents:
      a) HCBS LOC review: Required documentation for QA Reviews (Frail Elderly (FE), Physical Disability (PD), Brain Injury (BI));
      b) HCBS LOC Review: Required Documentation for QA Reviews (Autism (AU));
      c) HCBS LOC Review: Required Documentation for QA Reviews (Intellectual/Developmental Disability (IDD));
      d) HCBS LOC Review: Required Documentation for QA Reviews (Technology Assisted (TA));
      e) HCBS LOC Review: Required Documentation for QA Reviews (Severe Emotional Disability (SED)
      f) HCBS MCO Record Review: Required Documentation for QA Reviews (Except SED);
      g) HCBS MCO LOC and Record Review: Required Documentation for SED QA Reviews;
      h) QMS' official case review record and findings are in QRT.
   2. Required documentation is subject to change and will be updated on the specific record review document sent out via email at the beginning of every upload period.
   3. For the required documentation, assessing entities/MCOs must provide all current and prior documentation that demonstrates compliance with CFR Regulations, performance measures, applicable policies, and program mandates for every day of the review period.

B. LOC Performance Measure Documentation
   1. The LOC assessing entity is responsible for providing appropriate documentation for this section of the audit review.
   2. Requests for LOC documentation may include, but is not limited to:
      a) Specific waiver eligibility assessment, applicable re-assessments, and any medical documentation if required for eligibility;
      b) Initial Intake/Referral Form;
      c) 3160 approval/Functional Eligibility Assessment request from the specific waiver program manager – if coming off a waitlist or is a crisis/exception, when the initial assessment has expired and will need a new assessment to be eligible for the waiver.

Documentation continued

C. Service Plan and Health and Welfare Performance Measure Documentation
   1. The MCOs are responsible for providing the appropriate documentation for this section of the audit review.
   2. Requests for Service Plan and Health and Welfare Documentation may include, but are not limited to:
      a) 3160 and 3161 – include the initial notification from the eligibility worker of a new member;
      b) PCSP for current and prior PCSP to determine timeliness. The following is considered part of the individual's PCSP and is subject to review:
         i. Documentation of participant choice, as directed by the waiver;
         ii. Physical, Functional, and Behavioral Assessment;
         iii. Back up plan;
         iv. Evidence of information provided on reporting suspected abuse, neglect, and exploitation; and
         v. Goals
      c) Physician/Registered Nurse (RN) Statement (if applicable);
      d) Legal representative, DPOA, and/or guardianship paperwork
      e) Physical exam;
      f) Evidence of rights and responsibilities discussed with participant and/or representative/guardian;
      g) Evidence of appeal and grievance rights/processes discussed with participant and/or representative/guardian;
      h) Notice of Actions (for any updates or changes in Service Plans, including annual reviews and/or adverse actions);
      i) Log or case notes (inclusive of verification of services being received in the type, scope, amount, duration, and frequency specified in the Service Plan);
      j) BI Waiver only - Progress notes for Transitional Living Skills and/or Therapies.
      k) SED Only: Documentation on Critical Incidents/APS/CPS reports regarding restraints, seclusion, or other restrictive interventions and/or anything in the AIR system.

8100. COPAYMENT Updated 12/10

HCBS autism waiver services are exempt from copayment requirements.

8300. BENEFIT PLANS Updated 05/19

KMAP members are assigned to one or more KMAP benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

To meet documentation requirements, applicants must include in their enrollment packet all items which are relevant to the identified service they are seeking to provide from the list below:

- Current license
- Transcripts (if a transcript does not indicate autism specifically, must attach syllabi)
- Supervisor's statement on official letterhead verifying the hourly requirement
- Copy of master's degree, bachelor's degree, high school diploma, or equivalent
- Resume
- Copy of records indicating Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid Registry, and Motor Vehicle screens successfully passed

8400. MEDICAID Updated 10/17

HCBS AUTISM WAIVER PROGRAM

Once a child has received a diagnosis of an ASD, they must also meet the level of care (functional) eligibility guidelines utilizing the state-approved functional eligibility instrument. The POC is developed by the Managed Care Organization (MCO) and will describe the waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written POC. The POC will be subject to approval by the selected MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written POC.

Once a child has completed the three years of service (or, when approved, four years of service) or found to not be eligible for the HCBS Autism waiver, the child may transition to whichever waiver the family and child feels will meet their needs and the child meets functional eligibility.

- **HCBS Intellectual and Developmental Disability (I/DD)**: If the child meets the eligibility criteria, as determined by the I/DD waiver, they may bypass the waitlist during their transition.
- **HCBS Severe Emotional Disturbance (SED)**: If the child meets the eligibility criteria, as determined by the SED waiver, the child may transition to the SED waiver.
- **HCBS Technology Assistance (TA)**: If the child meets the eligibility criteria, as determined by the TA waiver, the child may transition to the TA waiver.

Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease are not covered.

Enrollment

Potential providers must complete a KMAP provider enrollment application and submit their credentials and qualifications with the application. The fiscal agent reviews the application and forwards the application to the HCBS Autism waiver program manager. Once the program manager determines the provider meets the qualifications, the fiscal agent notifies the potential provider of the enrollment determination.

8400. MEDICAID Updated 10/17

FAMILY ADJUSTMENT COUNSELING
Submit code S9482 to bill Family Adjustment Counseling services at an individual rate.
Submit code S9482 HQ to bill Family Adjustment Counseling services at a group rate.

Family Adjustment Counseling can be provided to the family members of a child with an ASD in order to guide and help them cope with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required for the child. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family Adjustment Counseling offers the family a mechanism for expressing the emotions associated with the comprehension of the disorder and for asking questions about the disorder in a safe and supporting environment. When acceptance of the disorder can be achieved, the family is prepared to support the child on an ongoing basis. The service is provided by a Licensed Mental Health Professional (LMHP).

For the purposes of this service, "family" is defined as unpaid persons who live with or provide care to the member served on the waiver and may include a parent, stepparent, legal guardian, sibling, relative, or grandparent. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized POC.

Family Adjustment Counseling does not duplicate any other Medicaid State Plan Service or other services otherwise available to the member at no cost. Family Adjustment Counseling provides the family with the ability to meet with a counselor who is a LMHP to assist in coping with the child's illness and the related stress that accompanies the initial understanding of the diagnosis, and the ongoing, continuous, and daily care required for the child with an ASD. This model allows the family to meet with a counselor without the child present.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

- Documentation must be legible, accurate, and timely. A member's file may be requested for review by the state program manager for quality assurance reviews.
- If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.
- Services provided must be documented within the billed time frame.
- Transportation to and from school, medical appointments, community-based activities, and/or any combination of these are included in the rate paid to providers of this service.

Documentation ***at a minimum*** includes:

- The service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided

FAMILY ADJUSTMENT COUNSELING continued

- Name of family adjustment counseling service provider, legibly printed, with signature verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400-hour clock
  Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

Limitations

- The group membership requirement for Family Adjustment Counseling is to have a family member with a diagnosis of an ASD.
- Families must agree to a group setting.
- Family Adjustment Counseling is limited to 12 hours per calendar year.
- Families may request more hours from their MCO if needed.
- Services are subject to prior approval and must be intended to achieve the goals or objectives identified in the child's individualized behavioral POC.
- Group settings cannot consist of more than three families.
- Delivery of this service may occur via telemedicine, telehealth, or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three written statements from service providers in at least a 50-mile radius declining to provide services because the member resides in a location that is so remote or far away that the provider does not have the staff to meet with the child on a continual and/or intermittent basis as needed.

Reimbursement

Payment for Family Adjustment Counseling services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- **License**
  - The LMHP must hold a current license to practice in the state of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564.
- **Other Standards**
  - Adherence to KDAD's training and professional development requirements
  - Maintenance of clear background as evidenced through background checks of the KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen
    Note: The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.
  - Medicaid-enrolled provider
  - MCO-contracted provider
    Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

8400. MEDICAID Updated 10/17

PARENT SUPPORT AND TRAINING (PEER TO PEER)
Submit code T1027 to bill Parent Support and Training services at an individual rate.
Submit code T1027 HQ to bill Parent Support and Training at a group rate.

Parent Support and Training is designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Parent Support and Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family with the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their ASD and treatment and development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management.

For the purposes of this service, "family" is defined as persons who live with or provide care to a child served on the waiver and may include a parent, stepparent, legal guardian, sibling, relative, grandparent, or foster parent. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized POC.

- Support, coaching, and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
  Note: This involves helping the families identify and use healthy coping strategies to decrease caregiver strain; improve relationships with family, peers, and community members; and increase social supports.
- Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to their mental illness and treatment.
- Develop and enhance the family's specific problem-solving skills, coping mechanisms, and strategies for the member's symptom and behavior management.
- Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and POC process.
- Provide educational information and understanding on the member's medications or diagnoses
- Interpret the choices offered by service providers.
- Assist with understanding policies, procedures, and regulations that impact the member with mental illness while living in the community.
- Provide information on supportive resources in the community.
  Note: This service must be intended to achieve the goals and/or objectives identified in the member's individualized POC.

Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to the member at no cost.

The Parent Support and Training provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

8400. MEDICAID Updated 10/17

PARENT SUPPORT AND TRAINING (PEER TO PEER) continued
Services furnished to a member who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities or institution for mental disease are not covered.

No more than one Parent Support and Training worker may be paid for services at any given time of day.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

- Documentation must be legible, accurate, and timely. A member's file may be requested for review by the state program manager for quality assurance reviews.
- If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.
- Services provided must be documented within the billed time frame. Transportation to and from school, medical appointments, community-based activities, and/or any combination of these are included in the rate paid to providers of this service.

Documentation ***at a minimum*** includes:
- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of Parent Support and Training service provider, legibly printed, with signature on each page verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock
  Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

Reimbursement
Payment for Parent Support and Training services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations
- Group settings cannot consist of more than three families.
- The group membership requirement for Parent Support and Training is to have a family member with a diagnosis of an ASD.
- Families must agree to a group setting.

8400. MEDICAID Updated 10/17

PARENT SUPPORT AND TRAINING (PEER TO PEER) continued

- Delivery of this service may occur via telemedicine, telehealth, or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three written statements from service providers in at least a 50-mile radius declining to provide services because the member resides in a location that is so remote or far away that the provider does not have the staff to meet with the child on a continual and/or intermittent basis as needed.

Provider Requirements - Parent Support Provider

The provider must:

- Be 21 years of age or older
- Have three years of direct care experience working with a child with an ASD or be the parent of a child with an ASD
- Have a high school diploma or equivalent
- Have completed parent support training program or other approved training curriculum
- Be a Medicaid-enrolled provider
- Be an MCO-contracted provider

Other standards

- Adherence to KDADS training and professional development requirements
- Maintenance of clear background as evidenced through background checks of KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen
  Note: The Motor Vehicle screen can be waived for positions which DO NOT require driving as a function of the position.
  Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Provider Requirements - Community Service Providers and Community Mental Health Centers

- Community service providers must be licensed by KDADS.
- Community Mental Health Centers (CMHCs) must be licensed under K.A.R. 30-60-1.
- All licensed agencies on file with the Secretary of State's office that are or can become Medicaid enrolled and employ individuals that meet the qualifications of a Parent Support and Training provider must be agencies approved to enroll in Medicaid to provide HCBS services. These are listed on the HCBS application on the Provider Enrollment Applications page of the KMAP website.

The provider must:

- Be 21 years of age or older
- Have three years of direct care experience working with a child with an ASD or be the parent of a child with an ASD
- Have a high school diploma or equivalent
- Have completed parent support training or other approved training curriculum
- Be a Medicaid-enrolled provider
- Be an MCO-contracted provider

8400. MEDICAID Updated 010/17

PARENT SUPPORT AND TRAINING (PEER TO PEER) continued

Other standards

- Adherence to KDADS training and professional development requirements
- Maintenance of clear background as evidenced through background checks of KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen
  Note: The Motor Vehicle screen can be waived for positions which DO NOT require driving as a function of the position.
  Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

8400. MEDICAID Updated 08/23

RESPITE CARE
Submit code T1005 to bill these services.

Respite Care provides temporary, direct care and supervision for the child. The primary purpose is relief to families and caregivers of a child with an ASD. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing Respite Care and include support in the home, after school or at night.

Respite Care can be facilitated by an agency-directed or self-directed provider. If self-directed care is utilized, modifier U6 must be attached to the claim to differentiate between self-directed and agency-directed Respite Care Services.

- Transportation to and from school, medical appointments, other community-based activities, and/or any combination of these is included in the rate paid to providers of this services.
- FFP is not claimed for the cost of room and board.
- Respite Care does not duplicate any other Medicaid State Plan Service or service otherwise available to the member at no cost.
- The Respite Care provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.
- No more than one Respite Care provider may be paid for services at any given time of day.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the member receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

- Documentation must be legible, accurate, and timely. A member's file may be requested for review by the state program manager for quality assurance reviews.
- If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.
- Services provided must be documented within the billed time frame.

Documentation ***at a minimum*** includes:

- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of Respite Care service provider, legibly printed, with signature on each page verifying that every entry reflects activities
- Signature of parent or legal guardian to verify services were received as documented
- Type of service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

RESPITE CARE continued

Limitations

- Respite Care services are available to members with a family member who serves as the primary caregiver and is not paid to provide any HCBS Autism waiver service to the child.
- Respite Care cannot be provided by a parent of the child.
- Respite Care cannot be provided to a member who is an inpatient of a hospital or State Mental Hospital when the inpatient facility is billing Medicaid, Medicare, and/or private insurance.
- Respite Care services are subject to prior approval.
- Respite Care is provided in planned or emergency segments and may include payment during the member's sleep time.
- Respite Care has a soft limit of 168 hours per calendar year. Families may request additional hours of Respite Care by contacting their MCO care coordinator.

Reimbursement

Payment for Respite Care services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Self-directed services will require the use of Financial Management Services (FMS) utilizing the T2040 U2 code for reimbursement. Beginning on December 3, 2023, providers must submit claims via the state's Electronic Visit Verification (EVV) system when self-directed or agency directed Respite Care Services are utilized.

Provider Requirements Agency-Directed Respite Care Provider

The provider must:

- Be 18 years of age or older
- Have a high school diploma or equivalent
- Meet the family's qualifications
- Reside outside of the member's home
- Have completed the state-approved training curriculum

Other standards

- Adherence to KDADS training and professional development requirements
- Maintenance of clear background as evidenced through background checks of KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen.
  Note: The Motor Vehicle screen can be waived for positions which DO NOT require driving as a function of the position.
  Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Provider Requirements - Self-Directed Respite Care Provider

The provider must:

- Be 18 years of age or older
- Have a high school diploma or equivalent
- Meet the family's qualifications
- Reside outside of the member's home
- Have completed the state-approved training curriculum

RESPITE CARE continued

Other Standards

- Adherence to KDADS training and professional development requirements
- Maintenance of clear background as evidenced through background checks of KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen.
- Self-directed services will require the use of FMS utilizing the T2040 U2 code for reimbursement.

Note: The Motor Vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Provider Requirements - Community Service Providers and CMHC

- Community service providers must be licensed by KDADS.
- CMHCs must be licensed under K.A.R. 30-60-1.

The provider must:

- Be 18 years of age or older
- Have a high school diploma or equivalent
- Meet the family's qualifications
- Reside outside of the member's home
- Have completed the state-approved training curriculum

Other standards

- Adherence to KDADS training and professional development requirements
- Maintenance of clear background as evidenced through background checks of KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen

  Note: The Motor Vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

  Note: Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS AUTISM SERVICES

Updated 08/24

1. Services are provided according to the POC, in a quality manner, and as authorized on the Notice of Action.
2. Provision of services is coordinated in a cost-effective and quality manner.
3. Member's independence and health are maintained, where possible, in a safe and dignified manner.
4. Member's concerns and needs, such as changes in health status, are communicated to the MCO care coordinator within 48 hours, including any ongoing reporting as required by the Medicaid program.
5. Any failure or inability to provide services as scheduled in accordance with the POC must be reported immediately, but at least within 48 hours, to the MCO care coordinator.

KDADS has established an adverse incident reporting and management system in accordance with the statutory requirements under 1915 (c) of the Social Security Act and the health and welfare waiver assurance and associated sub-assurances.

Adverse Incident Reporting & Management
The Adverse Incident Reporting (AIR) system is designed for KDADS service providers and contractors to report all adverse incidents and serious occurrences involving individuals receiving services from KDADS. Providers can access the AIR system from the KDADS Home page under the **Quick Links** heading.

I. General Requirements

A. All HCBS providers shall make adverse incident reports in accordance with this policy as set forth herein.
B. All adverse incidents including those required to be reported to the Department of Children and Families (DCF), shall be reported to KDADS by direct entry into the KDADS web-based AIR system no later than 24 hours after becoming aware of the adverse incident.
C. Incidents shall be classified as adverse incidents when the event brings harm or creates the potential for imminent serious harm to any individual eligible to receive HCBS waiver services at the time of the occurrence.
D. A report shall be made into the AIR system for any adverse incident regardless of the location where it occurred. Location includes, but is not limited to, any premises owned or operated by a provider or facility licensed by KDADS; operating under the Older Americans Act or the Senior Care Act; or operating under the Money Follows the Person program or the Behavioral Health Services programs.
E. KDADS Program Integrity and Compliance (PIC) shall offer AIR system training to MCO staff, and all interested and involved parties. Training materials shall be provided on site and on the KDADS website.

Updated 08/24

II. Adverse Incident Definitions

A. **Abuse:** Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a member, including:
   1. Infliction of physical or mental injury
   2. Any sexual act with a member that does not consent or when the other person knows or should know that the member is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship
   3. Unreasonable use of a physical restraint, isolation, or medication that harms or is likely to harm the member
   4. Unreasonable use of a physical or chemical restraint, medication, or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the member or another individual
   5. A threat or menacing conduct directed toward the member that results or might reasonably be expected to result in fear or emotional or mental distress to the member
   6. Fiduciary abuse
   7. Omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness

B. **Chemical Restraint**: Any medication used to control behavior or to restrict the member's freedom of movement and is not a standard treatment for the member's medical or psychiatric condition.

C. **Death:** Cessation of a member's life.

D. **Elopement:** The unplanned departure from a unit or facility where the member leaves without prior notification or permission.

E. **Emergency Medical Care:** Inpatient or outpatient hospital services that are necessary to ensure the health and welfare of the member which require use of the most accessible hospital available and equipped to furnish those services.

F. **Exploitation:** Misappropriation of the member's property or intentionally taking unfair advantage of a member's physical or financial resources for another individual's personal or financial gain by the use of undue influence, coercion, harassment, duress, deception, false representation, or pretense by a caretaker or another person.

G. **Fiduciary Abuse:** A situation in which any person who is the caretaker of, or who stands in a position of trust to, a member, takes, secretes, or appropriates their money or property to any use or purpose not in the due and lawful execution of such person's trust or benefit.

H. **Law Enforcement Involvement:** Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes, and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.

I. **Misuse of Medications:** The incorrect administration or mismanagement of medication by someone providing HCBS which results in or could result in serious injury or illness to a member.

J. **Natural Disaster:** A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented, and reported as required by the policy in the AIR system. A separate AIR report shall be made for all HCBS members in the area who are impacted by the natural disaster.
K. **Neglect:** The failure or omission by a caretaker, or another person with a duty to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
L. **Physical Restraint**: Any manual method of physical object or device attached or adjacent to a member's body that restricts the member's freedom of movement.
M. **Seclusion:** The involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving.
N. **Self-Neglect:** The failure or omission by oneself to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
O. **Serious Injury:** An unexpected occurrence involving the significant impairment of the physical condition of a member. Serious injury specifically includes loss of limb or function.
P. **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
Q. **Suicide Attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

III. Adverse Incident Reporting Requirements

A. Reporting Abuse, Neglect, Exploitation (ANE), and Fiduciary Abuse.
    1. ANE and Fiduciary Abuse shall be reported to DCF as required by K.S.A. 39-1431, K.S.A. 38-2223.
    2. ANE and Fiduciary Abuse reported to DCF shall also be reported to KDADS. When ANE and Fiduciary Abuse is reported to KDADS, the report shall identify the date of report to DCF and the intake number.
    3. ANE and Fiduciary Abuse reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
    4. ANE and Fiduciary Abuse reports require KDADS confirmation before final resolution. KDADS shall verify the following:
        a) A preventable cause was accurately identified; and
        b) The MCO observed appropriate follow-up measures.
    5. The MCO investigation shall verify the following:
        a) That appropriate follow-up actions are taken against the alleged perpetrator to minimize the risk of reoccurrence; and
        b) That appropriate supports are in place to assist the alleged victim to address any concerns they may have as a result of the occurrence.
B. Reporting Seclusion, Physical Restraint and Chemical Restraint
    1. Seclusion, Physical Restraint, and Chemical Restraint reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
    2. Seclusion, Physical Restraint, and Chemical Restraint reports shall require KDADS confirmation before final resolution. KDADS confirmation process shall examine if:
        a) The intervention was authorized or unauthorized; and

b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.

3. The MCO investigation shall verify that:
    a) The application of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, complied with the procedures specified in the approved waiver; and
    b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.
4. Chemical Restraint Reporting: The requirement for reporting chemical restraints is to provide tracking and trending data to ensure the health and welfare of the member. Follow-up measures shall verify that the necessary supports are in place for the member.
    a) Authorized Use of Chemical Restraint: Authorized use of chemical restraint is defined as the administration of any medication which follows the member's current Person-Centered Service Plan (PCSP).
        i. The medication must be prescribed and approved by a licensed healthcare provider.
        ii. The approved use must comply with the policy established per the setting.
        iii. Medication administration must follow the member's PCSP.
        iv. Any prescribed medication with the intended purpose of altering a member's behavior as warranted by the current situation. A report is required when a prescribed medication is administered on an interval beyond or at a dosage above the routinely scheduled regimen as documented in the member's PCSP.
    b) Unauthorized Use of Chemical Restraint: Unauthorized use of chemical restraint is defined as the administration of any medication that is not authorized for use in the member's current PCSP.
        i. A report must be filed whenever medication is administered as a chemical restraint, as defined above, regardless of whether it is prescribed or over the counter. No reporting is necessary if the medication is administered within the confines of its prescription and is not used as a chemical restraint.

C. Reporting Death
1. Death reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
2. Death reports require KDADS confirmation before final resolution. KDADS shall verify the following:
    a) The deceased's expectancy of death was accurately reported.
    b) The deceased's hospice status was accurately reported.
    c) Any preventable cause was accurately identified; and
    d) The MCO observed appropriate follow-up measures.
3. The MCO investigation shall verify:
    a) If the death was expected or unexpected.
    b) If there was a preventable cause of death; and

c) If the deceased was a recipient of hospice, then the MCO shall verify supporting documents in the form of a physician's order or hospice admission documentation.

D. Reporting of All Other Adverse Incidents:
   1. The reporting of all other adverse incidents, as defined in this policy, not required via K.S.A. 39-1433, K.S.A.38-2223, shall be made through the AIR system.

Military Inclusion

Active duty or honorably discharged military personnel and/or immediate family members are permitted to bypass the waitlist for HCBS programs in acknowledgment of their dedication and service to the United States of America.

I. Policy

A. KDADS determines HCBS waiver program eligibility for all HCBS waivers in the State of Kansas.
   1. Each current and approved HCBS waiver program has reserved capacity for active or honorably discharged military personnel and/or immediate family members.

B. Active or honorably discharged eligible military personnel and/or immediate family members (eligible dependents) may bypass the HCBS program waitlists, and access services, if the following criteria are met:
   1. The military personnel must show proof of active-duty service or an honorable discharge.
      a) Proof of active service or honorable discharge shall be any of the following:
         i. Most recent copy of Leave and Earning Statement (LES)
         ii. Valid Military Identification Card
         iii. Certificate of Release or Discharge from Active Duty (Form DD-214)
   2. The military personnel, or eligible dependent, must present documentation showing proof of:
      a) Coverage under Tricare Extended Care Health Option (ECHO) during the time of military service; or
      b) Coverage under Tricare Extended Care Health Option (ECHO) at the time of separation from active military service.
   3. Be a Kansas resident, by maintaining or demonstrating the intent to make Kansas the principal place of residency, consistent with K.S.A.79-39,109 and K.A.R. 95-12-4a.
      a) Evidence supporting residency or demonstrating the intent to establish residency, may include, but is not limited to, the following:
         i. Proof eligible military personnel is registered to vote in Kansas
         ii. Proof eligible military personnel has filed a Kansas resident income tax return for the most recent taxable year
         iii. Proof eligible military personnel have current motor vehicle registration in Kansas
         iv. Proof eligible military personnel hold a current valid Kansas driver's license or non-driver identification card

4. A dependent of military personnel residing in the state of Kansas may qualify for military inclusion exception.
    a) A qualifying dependent must meet the criteria for dependency as defined by the Internal Revenue Service (IRS).
    b) Evidence supporting dependency may include, but is not limited to, the following:
        i. Recent tax return
        ii. Marriage license
        iii. Birth certificate
        iv. Court order
        v. Adoption documentation
5. The eligible military personnel or their eligible dependent must meet the functional eligibility, program eligibility, and financial eligibility requirements for the HCBS waiver program that they have requested.
    c) Financial eligibility for all HCBS waiver programs is determined by the Kansas Department for Health and Environment (KDHE)

II. Procedures

A. Functional Eligibility Determination
    1. If an active or honorably discharged military personnel and/or their dependent is referred to an assessing entity for functional assessment, and if the individual requests an exception based on military inclusion, the assessor shall collect the proof of the following:
        a) Kansas residency
        b) Military member's or dependent's Tricare Echo Verification Documentation, and
        c) Proof of active-duty service through documentation (such as Form DD-214)
        d) Proof of dependency on qualified military personnel (when applicable)

B. Applicant shall provide required supporting proof of military service to the assessing entity at the time of functional assessment:
    1. If such documentation is not available at the time of functional assessment, the assessor shall proceed with completing a functional assessment based upon applicable current/approved waiver program requirements, policy, and procedures.
        a) Supporting proof of military service must be provided to the state's designated system of record no later than five days after the functional assessment to be considered for inclusion exception during program eligibility determination.
        b) The assessor must notify the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception.

C. For individuals separating from active-duty military service:
    1. A functional assessment must be completed within 30 days of termination of active duty or separation from military service to be considered for the military inclusion exception.
    2. If an individual meets the functional eligibility but fails to meet the requirements for a military inclusion exception, then the individual may:
        a) Access an HCBS program in the same manner as any other applicant found functionally eligible; or
        b) Be placed on the appropriate waitlist as of the date of functional eligibility if the qualifying HCBS program has a waitlist.

D. After validating the proof of military service and determining that an eligible military personnel or eligible dependent meets the requested HCBS waiver functional eligibility criteria:
    1. The assessor shall follow functional assessment and waiver eligibility procedures of the relevant HCBS waiver program.
        a) The assessor shall notify, using the state-designated communication method, the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception listed in the Section I of this policy.
    2. KDADS may request the supporting documentation proving eligibility for military inclusion exception from the assessor, or directly from the individual deemed eligible for military inclusion exception to support a program eligibility determination.

E. If the assessor determines the individual seeking military inclusion exception for themselves or their dependent is not functionally eligible for the HCBS waiver program:
    1. The assessor shall follow waiver policies and procedures applicable to the waiver program that the applicant has applied.
    2. The assessor shall counsel the applicant on alternative community options and services, including services available through the Veterans Affairs (VA) Administration.

III. Documentation

A. KDADS HCBS Program Manager shall follow established current/approved HCBS waivers, policy, and procedures in requesting and responding to requests for waiver program eligibility.

IV. Definitions

A. **Financial Eligibility** – The process whereby a member is determined to be eligible for health care coverage for reimbursement through Medicaid as determined by an authorized agent or personnel designated by the State. In this case, the Single State Medicaid Agency is the KDHE.

B. **Functional Assessment** – The current KDADS approved tool used by a state-contracted assessor to assess a person's functional eligibility.

C. **Functional Eligibility** - The process whereby a member is determined to meet the level of care need for an institutional setting to access a Medicaid-funded HCBS waiver program as determined by a state-contracted assessor.
D. **Military Personnel** – Active or reserve duty members of the armed forces including the United States Army, Navy, Marines, Air Force and Coast Guard, as well as, the activated Kansas National Guard.
E. **Program Eligibility** – The process whereby a member is determined to be eligible for a Medicaid-funded KDADS HCBS waiver program as determined by KDADS or its designated State agency.
F. **Resident** – A citizen of the United States who has a fixed home in Kansas, does not intend to leave Kansas and whenever absent, if for temporary purposes, intends to return to Kansas as evidenced by several factors found in K.A.R. 92-12-4a, including, but not limited to, spending more than six months of the taxable year in Kansas, voting or being registered to vote in Kansas, obtaining or maintaining a current valid driver's license or non-driver identification card, and paying Kansas income and property taxes and that person's domicile is within Kansas.
G. **State-contracted Assessor** – Authorized agent or personnel, approved by the State, responsible for completing the functional eligibility assessments for individuals applying for KDADS HCBS waiver programs.

APPENDIX

CODES

Updated 10/17

The following codes represent a list of HCBS Autism waiver services billable to KMAP for HCBS Autism waiver members.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information from the public website
- Information from the secure website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Ambulance Coding Modifiers Table and Coding Modifiers Table are available on both the public and secure websites. They can be accessed from the **Reference Codes** link under the ***Interactive Tools*** heading on the Provider page and Pricing and Limitations on the secure portion. Information is also available on the American Medical Association website.

FAMILY ADJUSTMENT COUNSELING
S9482
S9482 HQ

PARENT SUPPORT AND TRAINING SERVICES
T1027
T1027 HQ

RESPITE CARE
T1005