Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS

Severe Emotional Disturbance

Updated 07.2025

PART II

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE WAIVER PROVIDER MANUAL

Introduction

FORMS: All forms pertaining to this provider manual can be found on the Kansas Medical Assistance Program (KMAP) public and secure portals under Publications and Forms.

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 SED PROGRAM

Updated 11/22

The Serious Emotional Disturbance (SED) waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert psychiatric hospitalization through the provision of intensive Home and Community Based Services (HCBS) to maintain children and youth in their homes and communities. The Kansas SED waiver provides six services to participants and their families that are not available to other Medicaid youth. These services are:

- Independent Living/Skill Building
- Parent Support and Training- Individual and Group
- Short Term Respite Care
- Wraparound Facilitation
- Professional Resource Family Care
- Attendant Care

Participants eligible for the waiver are between the ages of 4 and 18. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a serious emotional disturbance and are at risk for inpatient psychiatric hospitalization. Foster care children/youth on the SED waiver will not be able to access short term respite care or professional resource family care. The foster care contractor can arrange for children/youth access to these two services through their contract with the state.

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A participant must have a mental health diagnosis determined by a Qualified Mental Health Professional (QMHP) and qualifying scores on two standardized assessment tools. These tools are the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL). An initial Eligibility Packet is complete and sent to the Kansas Department of Aging and Disability Services (KDADS) for confirmation that Functional eligibility is met. Financial eligibility is determined by the Kansas Department of Health and Environment (KDHE).

The SED waiver is managed by the operating agency KDADS. SED waiver services are provided by Community Mental Health Centers (CMHC).

Each waiver participant will have a person-centered service plan. The service plan is developed by the Managed Care Organization (MCO) and will describe 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 service plan. The service plan will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written service plan.

Programmatic oversight and control of the waiver is provided by KDADS. KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver. This is accomplished by setting adequate standards for all providers that furnish HCBS/SED waiver services and ensuring those standards are met prior to furnishing waiver services.

The HCBS SED waiver services require prior authorization (PA) through the service plan process.

INTRODUCTION TO THE HCBS SED PROGRAM

Updated 10/22

Enrollment
All HCBS SED providers must enroll in the Kansas Medical Assistance Program (KMAP) and receive a provider number for HCBS SED services. Contact the fiscal agent for enrollment.

HIPAA Compliance
As a participant in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services (HHS) 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 HHS all information required during its review and investigation. The provider is required to provide access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

BILLING INSTRUCTIONS

7000. HCBS SED BILLING INSTRUCTIONS Updated 10/22

Introduction to the CMS-1500 Claim Form
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. 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 and Instructions)* 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

7010. HCBS SED SPECIFIC BILLING INFORMATION Updated 04/23

Enter procedure code H2021 (Wraparound Facilitation), T2038 (Independent Living/Skill Building), S5110 (Individual) / S5110 TJ (Group) (Parent Support and Training), or S5150 (Short Term Respite Care), T1019-HK (Attendant Care) in Field 24D on the CMS-1500 claim form.

One unit = 1 hour (T2038)
One unit = 15 minutes (H2021, S5110, S5150, S5110J, T1019HK)
One unit = 1 day (S9485)

If client obligation has been assigned to a particular provider and this provider has been informed that he or she is to collect this portion of the cost of service from the client, the provider should not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Effective May 1, 2023, a new code has been added to the Electronic Visit Verification (EVV) system. This service code is to function in the same manner as the Home and Community Based Services (HCBS) codes already required to be billed via the Kansas EVV system. Providers must submit claims via the state's EVV system for the Severe Emotional Disturbance (SED) Waiver with the procedure code T1019-HK.

7010. HCBS SED SPECIFIC BILLING INFORMATION Updated 10/22

Overlapping Dates of Service

Unit Billing:

Service	Code	Limitation/Requirements	Unit Value
Short Term Respite Care (STRC)	S5150	Cannot be billed simultaneously with Professional Resource Family Care (PRFC). Overnight respite homes must be licensed as family foster homes in accordance with state statute and regulations. Waiver participants in Department of Children and Families (DCF) custody placed outside the home are not eligible for this service.	1 unit = 15 minutes
Parent Support & Training (PST) – Individual	S5110	Cannot be billed simultaneously with PRFC	1 unit = 15 minutes
PST - Group	S5110	Cannot be billed simultaneously with PRFC	1 unit = 15 minutes
Independent Living/Skills Building (ILSB)	T2038		1 unit = 1 hour
Wraparound Facilitation (WAF)	H2021	There are no limits on WAF. WAF is to occur at the initial Service Plan development and, at minimum, yearly review of the Person-Centered Service Plan (PCSP)/POC or more frequently with changes in the participant's circumstances warrant. Meetings can be telehealth or by conference call by member's choice when the meeting is **not** the initial or 6-month review.	1 unit = 15 minutes
Professional Resource Family Care (PRFC)	S9485	PRFC cannot be billed simultaneously with Short Term Respite Care (STRC). PRFC homes must be licensed as family foster homes in accordance with the state statute and regulations. Waiver participants in DCF custody placed out of home are not eligible for this service.	1 unit = 1 day
Attendant Care	T1019HK	There are no limits to Attendant Care. Services provided in an educational setting must not be educational in nature or duplicate other Medicaid State Plan services.	1 unit = 15 minutes

Same Day Service:
HCBS services provided prior to or after an approved inpatient stay on a service plan are allowed.

7030. HCBS SED 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)
            - Kansas Modular Medicaid System (KMMS)
            - Medicaid Management Information System (MMIS)
            - Quality Review Tracker (QRT)
            - Kansas Adverse Incident Reporting and Management System (AIRS)

7030. HCBS SED 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.

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.

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.

Quality Assurance Procedures 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.

7040. HCBS SED ELECTRONIC VISIT VERIFICATION Updated 01/25

Effective February 6, 2025, AuthentiCare will become the sole approved claims entry point for services that require Electronic Visit Verification (EVV). Initial Claims for EVV covered services that are not received from AuthentiCare will be denied. Claims will be created from AuthentiCare to cover all services, excluding WORK and STEPS that require EVV.

Claims Process

- Claims will be created using the information that comes from MCO and Gainwell FFS (payer) authorizations, caregiver visits, and provider data entry.
- Negotiated rates, up to 12 diagnosis codes, and ordering provider NPI information will be on the claim for the services being provided based on data in the authorization file from payers. Providers will select the appropriate diagnosis pointers for each service line.
- Caregivers will populate the Place of service (POS) where care takes place when submitting visit information. This will be populated into the claim.

Provider Responsibilities

Before confirming a visit in AuthentiCare to be submitted for claims processing, Provider Administrators will:

- Validate the information contained in the authorization including member, service, start and end dates, diagnosis code, ordering physician, number of approved units, and ensure that service rates are correct. If the claim billed amount is different than the calculated amount, the provider must update with their usual and customary billed amount. The provider is responsible for working with the payer to ensure a proper and accurate authorization is in the AuthentiCare system.
- Validate the visit information submitted by the caregiver.
- Address all critical exceptions found in the rules review process for visits in AuthentiCare by updating the visit information for accuracy, completeness and attesting to the accuracy of the visit information captured.
- Validate the TPL coverage information on the client record is accurate. If not, the provider will need to submit a request for an update through the KMMS provider portal.
- Validate the TPL adjudication information has been correctly entered on the claim for each TPL Payer.
- Validate and attest to the entry of all payor information related to Third Party Liability.
- Provider is responsible for the entry of TPL payments and CARC/RARCs and group codes in AuthentiCare.
- Confirm the visit for billing that will result in AuthentiCare building the claim and submitting it during its daily batch submission process.

Claims Adjustments

Providers may continue to submit claims adjustments through the provider portal. Ensure all required documentation and corrections are submitted timely.

8100. COPAYMENT Updated 10/22

HCBS SED services are exempt from copayment requirements.

8400. MEDICAID Updated 07/25

Only services described herein, provided by individuals listed, and provided in the manner described are reimbursable by Kansas Medicaid for HCBS SED providers.

Additionally, the existing Community Mental Health Center (CMHC) services are reimbursable by Kansas Medicaid for HCBS SED providers. Refer to the *CMHC Fee-for-Service Provider Manual* for these services.

Implementation of Virtual Delivery of Services:
Effective with dates of service on or after July 1, 2025, Virtual Delivery of Services (VDS) will be authorized across all HCBS Waivers. This new policy establishes the option for certain services to be provided electronically using a HIPAA-compliant, real-time audiovisual platform that enables staff to both see and hear the participant. This initiative supports greater autonomy, access, and flexibility for individuals receiving services, while maintaining compliance with federal privacy and safety requirements.

Definition:
VDS refers to the real-time provision of supports using secure audiovisual technology. Communication methods such as text messaging or email do not qualify as VDS under this policy and will not be considered direct service delivery.

Place of Service Codes:

- **Code 02:** VDS provided outside the participant's home
- **Code 10:** VDS provided within the participant's home

Place of service must be documented in the participant's Person-Centered Service Plan (PCSP).

Authorized Services and Applicable Codes:

Service	KMAP Codes
Parent Support & Training	S5110 (Individual) S5110 TJ (Group)
Wraparound Facilitation	H2021

Key Policy Considerations:

- **Informed Consent:** Participants or their legal representatives must sign a consent form confirming the choice between in-person and virtual service delivery, including a discussion of any potential health or safety concerns.
- **Hands-On Services:** VDS is not permitted for services requiring physical assistance.
- **Participant Choice:** VDS should not replace or discourage in-person services. Participants may switch to in-person services at any time; transition must occur within 7 days, or immediately if health/safety concerns arise.

8400. MEDICAID Updated 07/25

Implementation of Virtual Delivery of Services continued:

Key Policy Considerations continued:

- **Privacy:** Virtual service platforms must uphold participant privacy. Use of cameras in private spaces such as bathrooms and bedrooms is prohibited.
- **HIPAA Compliance:** All VDS must adhere to HIPAA Privacy and Security Rules.
- **Support for Technology Use:** Participants' need for assistance with VDS technology must be assessed and documented in the PCSP.
- **Service Frequency and Visit Modality:** Decisions regarding the extent and frequency of VDS, including any required in-person visits, will be determined and documented in the PCSP.

Independent Living/Skill Building:
Independent Living/Skill Building (IL/SB) services are designed to assist waiver participants who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Children may begin accessing this service at age 16.

Components of IL/SB

1. IL/SB activities are provided in partnership with waiver participants to help him or her arrange for the services needed to become employed, find transportation, housing, and continue their education.
2. Services are individualized according to each waiver participant's strengths, interests, skills, goals as specified in the Service Plan.
3. It would be expected that IL/SB activities take place in the community.
4. This service can be utilized to train and cue normal Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).
5. Housekeeping, homemaking (shopping, childcare, and laundry services), or basic services solely for the convenience of a waiver participant receiving IL/SB is not covered.
6. The following are examples of appropriate community settings rather than an all-inclusive list:
    a. A grocery store to shop for food,
    b. A clothing store to teach the participant what type of clothing is appropriate for interviews,
    c. An unemployment office to assist in seeking jobs or assist the participant in completing applications for jobs,
    d. Apartment complexes to seek out housing opportunities, and
    e. Laundromats to teach the participant how to wash clothing.
7. Other appropriate activities can be provided in other community setting as identified through the Service Plan process.
8. Transportation is provided between the participant's place of residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this service.

Independent Living/Skill Building continued

Limitations/Exclusions

1. Service requires PA
2. No limits; provider managed

This service will be provided by a trained IL/SB worker who will provide modeling, direction, and support to children and adolescents. The worker's training and areas of expertise require Mental Health and Developmental Disabilities approval and must meet the following requirements:

- Be at least 21 years of age
- Have a high school diploma or equivalent
- Completion of approved training in skill area(s) needed by transitioning youth according to a curriculum approved by KDADS prior to providing the service
- Must pass KBI, DCF child abuse check, adult abuse registry, and motor vehicle screens

Parent Support and Training

Parent Support and Training (PST) is designed to provide families of children who have been identified to have an SED and in need or at risk of more intensive level of care such as inpatient psychiatric hospital, psychiatric residential treatment facility (PRTF), or crisis.

Services may provide the training and support necessary to ensure engagement and active participation of the family in the treatment planning process with the ongoing implementation and reinforcements of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the participant. PST can be provided anywhere in the community that is agreeable to the individual. For the purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver, and may include parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting.

Components of PST

1. Support, coaching, and training provided to the family members to increase their ability to provide a safe and supportive environment in the home and community for the member
2. 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
3. Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the waiver participant in relation to their mental illness and treatment
4. Development and enhancement of the families specific problem-solving skills, coping mechanisms, strategies for the waiver participant's symptom/behavior management
5. Assist the family in understanding the various requirements of the waiver, such as the crisis plan and plan of care process
6. Educational information and understanding on the participant’s medications or diagnoses; interpreting choice offered by service providers; and assisting with the understanding policies, procedures, and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community
7. Services must be intended to achieve the goals and or objectives identified in the participant’s individualized service plan.

Parent Support and Training continued

Limitations and Exclusions

1. There are no limits; provider managed
2. Service requires PA
3. One full-time employee (FTE) to 10 participants/families is maximum group size
4. PST will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost
5. Operationally, individuals receiving PST do not simultaneously receive PRCF

The PST worker must meet the following criteria:

- High school diploma or equivalent
- Minimum 21 years of age
- Preference is given to parents or caregivers of children with SED
- Completion of PST according to a curriculum approved by KDADS within six months of hire
- Pass Kansas Bureau of Investigation (KBI), DCF child abuse check, adult abuse registry checks and motor vehicle screens

Short Term Respite Care

Short Term Respite Care (STRC) provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to families/caregivers of a participant with an SED in or outside the home.

Components of Short-Term Respite Care

1. The service is designed to help meet the needs of the primary caregiver, as well as the identified participant.
2. Normal ADLs are considered content of the service when providing respite care. These include:
    - Support in the home, after school, or at night
    - Transportation to and from school, medical appointments, or other community-based activities
    - And/or any combination of the above
3. STRC can be provided in an individual's home or place of residence or provided in other community settings if the safety of waiver participant is maintained.
4. The cost of transportation is included in the rate paid to providers of these services.
5. Overnight settings outside the family and/or relative's home must meet the applicable DCF licensure requirements.

Limitations/Exclusions

1. Service requires PA.
2. STRC is not available to participants in foster care because that service is available through foster care contracts. It can be provided to participants who are in state custody who are living at home.
3. STRC will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.

Short Term Respite Care continued

4. Other community settings which involve alternative financial coverage for placement including Licensed Foster Homes, Licensed Emergency Shelters, Out of Home Crisis Stabilizations houses/units/beds, or Institutions of Mental Diseases (IMD).
5. Service cannot be provided in a Youth Residential Center (YRC I or II) or Qualified Residential Treatment Program (QRTP).
6. Federal Financial Participation is not claimed for the cost of room and board.

Respite Care providers must meet the following criteria:

- High school diploma or equivalent.
- Minimum 21 years of age.
- Completion of respite training according to the curriculum approved by KDADS prior to providing the service.
- Pass KBI, DCF child abuse check, adult abuse registry checks and motor vehicle screens Individual or group
- Abuse registry and motor vehicle screens.
- Certification in First Aid, CPR, Crisis Prevention/ Management (example: Crisis Prevention Institute (CPI, Mandt, etc.)

Wraparound Facilitation

Wraparound Facilitation (WAF) is provided in addition to targeted case management to address the unique needs of a participant living in the community. WAF is used to bring the MCO, the participant, family, and community participants together to discuss HCBS and develop an individualized Person-Centered Service Plan (PCSP).

WAF cannot duplicate Target Case Manager (TCM) services and have to be requested by the participant and/or their family support network. WAF is intended to form the wraparound team for the purpose of establishing pertinent HCBS and develop an individualized PCSP. This includes working with the participant's family to identify who should be involved in the wraparound team and assembly of the wraparound team when initial and subsequent PCSP reviews and/or revision are needed. The TCM assists individuals with access to medical, social, educational, and other services outside of the waiver. The KanCare MCOs have delegated the provision of targeted case management to the State's CMHCs. The TCM and WAF may be the same person. TCM/WAF services cannot be billed at the same time by the same individual provider for the same participant. It is preferred that the TCM for one participant may be a WAF for a different participant.

Components of WAF

1. The function of the WAF is to form the wraparound team consisting of the participant's family, extend family, other community members involved with the participant's daily life, and the participant's chosen MCO, for the purpose of establishing the community-based services and develop the PCSP. This includes working with the participant's family to identify who should be involved in the wraparound team and assembly of the wraparound team when subsequent Service Plan review and revision are needed.
2. The WAF will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers. Wraparound teams meet at the minimum of yearly or more frequently when changes in the participant's circumstances warrant changes in the PCSP.

Wraparound Facilitation continued

3. The WAF provides ongoing wraparound services through the participants time on the SED waiver. WAFs will be certified after completion of specialized training on Kansas Train in the wraparound philosophy, waiver rules and processes, waiver eligibility and associated paperwork, structure of wraparound team and facilitation.

Limitations/Exclusions

1. WAF cannot duplicate any services provided by TCM Services.
2. If the WAF and the TCM are the same person, they may only bill for one service at a time.
3. Pay close attention when billing the allotted time for wraparound specifically verses TCM roles.

Facilitators must meet the following criteria:

- Minimum of Bachelor of Arts/Bachelor of Science (BA/BS) degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience· substituting for one year of education.
- Completion of WAF according to a curriculum approved by KDADS within one year of hire (6 months preferred).
- Pass KBI, DCF child abuse check, adult abuse registry and motor vehicle screens.
- WAFs will be certified after completion of specialized training in the wraparound philosophy, waiver rules and processes, waiver/grant eligibility and associated paperwork, structure of the waiver participant and family team, and meeting facilitation.

Professional Resource Family Care

Professional Resource Family Care (PRFC) is intended to provide intensive supportive resources for the waiver participant and family. This service offers intensive family-based support for the waiver participant's family through the utilization of a co-parenting approach provided to the waiver participant in a surrogate family setting. This service is provided outside the family home.

Components of Professional Resource Family Care

1. The goal is to support the waiver participant and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time.
2. During the time the professional resource family is supporting the waiver participant, there is regular contact with the family to prepare for the participant's return and ongoing needs as part of the family.
3. It is expected that the waiver participant, family and the professional resource family are integral members of the participant's individual treatment team.
4. Transportation is provided between the waiver participant's place of residence and other services sites or places in the community; and the cost of transportation is included in the rate paid to providers of these services.

Professional Resource Family Care continued

Limitations/Exclusions

1. Service requires a PA
2. Professional Resource Family Care (PRFC) may not be provided simultaneously with Short Term Respite Care services.
3. PRFC is not available to participants in out of home placement because that service is available through foster care contract (Therapeutic Foster Care).
4. FFP is not claimed for the cost of room and board.
5. PRFC does not duplicate any other Medicaid State Plan service or service otherwise available to the waiver participant at no cost.

Provider Qualifications

- High school diploma or equivalent
- Minimum 21 years of age
- Completion of state approved training according to a curriculum approved by KDADS prior to providing the service
- Pass KBI, DCF child abuse check, adult abuse registry, and motor vehicle screens
- Family residence licensed by DCF
- Certification in First Aid, CPR, Crisis Prevention/Management (example: CPI, Mandt, etc.)

Attendant Care [§1915(c)] / Personal Care:

The service enables the waiver participant to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cuing so that participant performs task by him/herself. Such assistance most often relates to performance of Activities of Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community.

Components of Attendant Care

1. Services should generally occur in community locations where the waiver participant lives, works, attends school, and/or socializes.
2. Services must be recommended by a wraparound team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in youth's PCSP.
3. Transportation is provided between the participant's place of residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services. KanCare MCOs will be responsible for all other transportation needs for the waiver participant.

Limitations/Exclusions

1. Services require a PA. Attendant Care has no unit limit.
2. Services provided at a work site must not be job tasks oriented.
3. Services provided in an educational setting must not be educational in purpose or duplicate services required to be provided by the educational institution.

Attendant Care [§1915(c)] / Personal Care continued

4. Services furnished to a waiver participant who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual or developmental disabilities, or institution for mental disease are non-covered.
5. Attendant Care does not duplicate any other Medicaid State Plan Service or service otherwise available to the waiver participant at no cost.

Provider Qualifications

- High school diploma or equivalent.
- Minimum 18 years of age and at least 3 years older than the youth.
- Completion of state approved training according to the curriculum approved by KDADS prior to providing the service.
- Pass KBI, DCF child abuse check, adult abuse registry, and motor vehicle screens.

EXPECTED SERVICE OUTCOME FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS SED SERVICES

Updated 08/24

1. Services are provided according to the service plan and in a quality manner and as authorized on the service plan.
2. Coordinate provision of services in a cost-effective and quality manner.
3. Maintain member's community placement whenever possible.

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.

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 if there is a documented concern for safety in the community.
E. **Emergency Medical Care:** Inpatient or outpatient emergency medical services that are necessary to ensure the health and welfare of the member which require use of the most accessible medical facility.
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.

Adverse Incident Reporting & Management continued

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.

APPENDIX I

PROCEDURE CODES AND NOMENCLATURE Updated 11/22

The following codes, plus the existing CMHC codes in Appendix I of the CMHC Provider Manual, represent an all-inclusive list of HCBS SED services billable to KMAP. Procedures not listed here are considered non-covered. Utilize the CPT codes listed [90000 series codes] for services rendered by a physician or licensed psychologist.

COVERAGE INDICATORS
PA = Prior Authorization is required.

COV.	PROCEDURE CODE	NOMENCLATURE
		INDEPENDENT LIVING/SKILL BUILDING
PA	T2038	Independent Living/Skill Building (one unit = 1 hour)
		PARENT SUPPORT & TRAINING
PA	S5110	Parent Support and Training – Individual (one unit = 15 minutes).
PA	S5110	Parent Support and Training – Joint (one unit = 15minutes)
		SHORT TERM RESPITE CARE
PA	S5150	Short Term Respite Care (one unit = 15 minutes)
		WRAPAROUND FACILITATION/COMMUNITY SUPPORT
PA	H2021	Wraparound Facilitation/Community Support (one unit = 15 minutes)
		PROFESSIONAL RESOURCE FAMILY CARE
PA	S9485	Professional Resource Family Care (one unit = 1 day)
		ATTENDANT CARE
PA	T1019HK	Attendant Care (one unit = 15 minutes)