Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Mental Health

Updated 08.2026

PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

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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.

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PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

Updated 03/18

This is the provider specific section of the provider manual. This section (Part II) was designed to provide information and instructions specific to mental health providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives instructions for completing and submitting the billing form mental health providers must use when the individual is **not assigned** to a Managed Care Organization (MCO). If the individual is assigned to an MCO, contact the specific health plan for managed care assistance.

The **Benefits and Limitations** subsection defines specific aspects of the scope of mental health services allowed within the Kansas Medical Assistance Program (KMAP).

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

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of 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.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality 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.

BILLING INSTRUCTIONS

7000. BILLING INSTRUCTIONS Updated 03/26

Introduction to the CMS-1500 Claim Form and UB-04

Mental health providers must use the CMS-1500 or UB-04 paper or equivalent claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website 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.

Examples of the CMS-1500 Claim Form and UB-04, along with their 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 or UB-04 to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

Third-Party Liability (TPL)

KMAP is a secondary payor to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. For more information see the *General TPL Payment Fee-for-Service Provider Manual*. For codes that do not need to be billed to other insurance including Medicare, refer to the TPL Non-Covered Procedure Code List under the Provider and Interactive Tools section.

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. SPECIFIC BILLING INSTRUCTIONS Updated 07/25

Unit Billing
The appendix provides procedure code and time definitions for billing specific procedures (for example, 15 minutes). When billing according to this definition, bill 1 unit in Field 24G.

When billing for less than the amount of time indicated in the definition (less than 1 unit), bill as follows:

.25 represents one-quarter of the time specified.
.50 represents one-half of the time specified.
.75 represents three-fourths of the time specified.

When billing for more than the amount of time indicated in the definition (more than 1 unit), bill as follows:

1.25 represents one and one-quarter units of the time specified.
1.50 represents one and one-half units of the time specified.
1.75 represents one and three-quarters units of the time specified.
2.00 represents two units of the time specified, and so forth.

Effective September 21, 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 Non-Waiver Mental Health Attendant Care (STC Authority) with the procedure code T1019-HE when provided in the home.

Certified Community Behavioral Health Clinic (CCBHC) Providers
Service codes listed in the Mental Health Provider Manual are not payable to a Community Mental Health Center (CMHC) if that same provider is enrolled as a CCBHC and the service code is listed in the CCBHC KMAP Provider Manual. For individuals in spenddown status please review **Section 7010. SPECIFIC BILLING INSTRUCTIONS in the KMAP CCBHC Provider Manual**.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/23

Effective with dates of service on and after January 1, 2024, copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

8200. DOCUMENTATION Updated 10/24

DOCUMENTATION

Documentation is **not** required to be in a standard format. The individual's record must include the following components:

A. Referral

a. Source of referral
b. Reason for referral

B. Pertinent Past and Present History

C. Treatment Plan

a. Psychological tests, procedures, and techniques to be used
b. Reviewed and updated appropriately

D. Evaluation

a. Interpretation of all completed/attempted psychological tests, procedures, and techniques used with conclusions reached
b. Recommendations related to meaningful aspects of the individual's everyday existence

Note: It is recommended that if an underlying cause of the maladaptive behavior is suspected of being physical in origin, a medical evaluation should precede a psychological evaluation. Results of the medical evaluation must also be documented in the record.

Note: Per the Centers for Medicare & Medicaid Services (CMS) and Kansas Medicaid, any claim submitted for reimbursement is subject to the applicable national coding guidelines. Payment received for claims not adhering to those standards is subject to recoupment upon review.

8300. BENEFIT PLAN Updated 05/24

KMAP service participants are assigned to one or more KMAP benefit plans. These benefit plans entitle the individual 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 eligibility verification.

- If the individual is assigned to an MCO:
  - All mental health services are the responsibility of the appropriate MCO. For more information, contact the specific health plan for managed care assistance.
  - To prevent potential billing and reimbursement errors, services provided when an individual is assigned to an MCO must be billed on a separate CMS-1500 Claim Form than services provided when an individual is not assigned to an MCO.
- If the individual resides in a Psychiatric Residential Treatment Facility (PRTF), all mental health services are the PRTF's responsibility.
- MediKan coverage is the same as for Medicaid service recipients with the following exceptions:
  - Individual outpatient psychotherapy is limited to 24 hours per calendar year per individual.
  - Group and family therapy in any combination are limited to 24 hours per calendar year per individual.
  - Psychological testing and assessment are limited to four hours every three calendar years, per individual, regardless of provider. Prior authorization will not override this limitation.
  - Targeted Case Management is limited to 80 hours per calendar year per individual.
    Note: For specific instructions, reference the *Targeted Case Management – Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page of the KMAP website.

Note: Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for complete details regarding Telemedicine.

Limitations

Electroshock treatments and psychotherapy may not be performed on the same date of service, regardless of provider.

Mental Health Services Not Covered by Medicaid

- Conference call
- Consultation in an ICF/IID facility
- Crisis Intervention in an institutional setting
- Holding therapy
- Hypnosis, biofeedback, or relaxation therapy
- Occupational therapy
- Perceptual therapy
- Phone call

8400. MEDICAID Updated 06/26

Evaluation and Management

These codes are used for encounters with health care professionals to evaluate and manage health conditions. National coding guidelines specify the criteria for the appropriate billing code to be utilized.

Note: Code 99211 (with modifier TD) may be reimbursed when provided by a registered nurse (RN) employed by a CMHC when the guidelines for billing this code are followed.

Psychiatric Evaluation

Assessment of the patient's psychosocial history, current mental status, and other physical examination elements and the ordering of diagnostic studies followed by treatment recommendations. Depending on the service delivered and code billed, additional medical services may be provided (such as prescribing medication).

Individual and Group Psychotherapy

Individual and group psychotherapy are covered when a treatment plan contains a psychiatric diagnosis and treatment goals. Psychotherapy is not covered for individuals whose only diagnosis is for intellectual or developmental disabilities. Therapy provided by a nonlicensed person is also not covered.

These mental health services are covered when provided by a Kansas LMHP as defined previously in **Section 8200**. Reimbursement will not be allowed for LMHPs to supervise a nonlicensed person who is doing therapy. This limitation is monitored postpay and requires the provider to document, in legible writing, the amount of time spent in therapy; major issues covered; and changes in medication, diagnosis, condition, treatment plan, or treatment course.

*The provider must document a review of the treatment plan of not more than 180 days.

Note: The waiver of not more than 90-day periodic treatment plan update to not more than 180-day period treatment plan update applies to the following:

- This waiver applies to licensed community mental health centers and licensed community mental health clinics as defined by K.S.A.39-2002(b).
- This waiver does not apply to any other category of licensure outlined in K.S.A.39-2002 including: crisis intervention center, hospital, private psychiatric hospital, psychiatric residential treatment facility, resident care facility or service provider. "Services" means the following types of behavioral health, intellectual disability, developmental disability and other disability services, including, but not limited to: residential supports, day supports, care coordination, case management, and shared living.
- This waiver also does not apply to Substance Use Disorder programs outlined in K.S.A.65-4001.

8400. MEDICAID Updated 06/26

Family Therapy

Family therapy involves treatment of the family as a "system," with the family being the focus of attention and change, specifically including children (may refer to adult children). Therefore, the service shall be billed as a family unit and not by the number of individuals involved in the treatment. The individual who is the primary KMAP recipient of services must be present during the delivery of service.

Family therapy is covered when a treatment plan contains a psychiatric diagnosis and treatment goals. This limitation is monitored postpay and requires the provider to document, in legible writing, the amount of time spent in therapy; major issues covered; and changes in medication, diagnosis, condition, treatment plan, or treatment course.

*The provider must document a review of the treatment plan of not more than 180 days.

Note: The waiver of not more than 90-day periodic treatment plan update to not more than 180-day period treatment plan update applies to the following:

- This waiver applies to licensed community mental health centers and licensed community mental health clinics as defined by K.S.A.39-2002(b).
- This waiver does not apply to any other category of licensure outlined in K.S.A.39-2002 including: crisis intervention center, hospital, private psychiatric hospital, psychiatric residential treatment facility, resident care facility or service provider. "Services" means the following types of behavioral health, intellectual disability, developmental disability and other disability services, including, but not limited to: residential supports, day supports, care coordination, case management, and shared living.
- This waiver also does not apply to Substance Use Disorder programs outlined in K.S.A.65-4001.

Home Based Family Therapy (HBFT) is a theoretical approach of counseling where the family system is the focus of treatment. Therapy is delivered in the family's home rather than in the therapist's office and is provided to a child with Serious Emotional Disturbance (SED) and the child's family by professionals who meet specific requirements. The service must be billed by the provider using modifier HK. Reference the Home-Based Family Therapy policy on the KDADS website for more information on the requirements for providing these services, guidelines for documentation, and process for billing.

8400. MEDICAID Updated 06/24

Psychological Testing/Assessment

Psychological testing/assessment is defined as the use, in any manner, of established psychological tests, procedures, and techniques with the intent of diagnosing adjustment, functional, mental, vocational, or emotional problems, or establishing treatment methods for individuals having such problems.

Testing performed by an uncertified assistant and supervised by a Ph.D. psychologist is covered when the psychological assessment conforms to the rules and regulations of the Behavioral Sciences Regulatory Board, 102-1-11.

Reimbursement for psychological testing includes the administration of standardized psychological tests, interpretation, and preparation of a written test report.

Psychological testing assessment documentation must:

- Clearly identify the questions and issues to be addressed
- Describe the individual at the time of the assessment
- Illustrate the need for initiating/continuing intervention
- Include the interpretation of findings with impressions and observations
- Give suggestions and recommendations

Note: Positive Behavior Supports (PBS) and Screening, Brief Intervention, and Referral for Treatment (SBIRT) information is available in **Section 8400** of the *Professional Fee-for-Service Provider Manual* on the Provider Manuals page of the KMAP website.

Services Provided to an Individual in an Inpatient or Residential Setting

Inpatient hospital visits are limited to those ordered by the individual's physician. Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, **group** psychotherapy is not covered when provided by psychologists, physicians, or CMHCs in a hospital setting. Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.

Services provided to a resident of an intermediate care facility for individuals with an intellectual disability (ICF/IID) or an individual receiving treatment in an institution for mental diseases (IMDs), including a PRTF, are considered content of the institutional or residential stay and should not be billed to KMAP.

8400. MEDICAID Updated 12/25

Behavioral Interventions

Two Behavior Intervention services are available for KBH-EPSDT members.

1. **Consultative Clinical and Therapeutic Services (CCTS)**
   Procedure codes 97151, 97152, 97153, 97154, 97155, 97156, and 97158 can be billed by provider type 11 and specialty 403. One unit is equal to 15 minutes.

   CMHC providers may provide these services. The rendering provider must be enrolled with KMAP with the appropriate provider type and specialties. The soft limits for this range of services would be for an initial 50 hours with additional hours authorized if medical necessity criteria is met.

   Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to prior authorization process.

   Provider Requirements
   - The provider must be a KMAP provider.
   - Certificate demonstrating individual is a Board-Certified Behavior Analyst (BCBA) ***OR*** Board-Certified Behavior Analyst – Doctoral (BCBA-D), ***OR*** Board-Certified Assistant Behavior Analyst (BCaBA), ***OR***
   - A letter signed by the Kansas Department for Aging and Disability (KDADS) Home and Community Based Services (HCBS) Autism Waiver Program Manager or HCBS Director. This letter will validate the applicant has met the alternative requirements for this enrollment:
     - An individual with a master's degree, preferably in Human Services or education with documented experience working with a child with an Autism Spectrum Disorder and completion of a State Approved Train Curriculum such as the KCART training.
   - The individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), and Nurse Aide Registry.

   Individuals who have met the requirements to be enrolled as a CCTS provider are deemed to have met the requirements to enroll as an Intensive Individual Supports provider. Provider will need to request this specialty when enrolling.

Behavioral Interventions continued

2. **Intensive Individual Supports (IIS)**
   Code 97153 and 97154 can be billed by provider type 11 and specialty 404. One unit is equal to 15 minutes. Initially, the soft limit for this service is up to 25 hours/week; but additional hours can be authorized with a demonstration that medical necessity criteria is met.
   Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to a prior authorization process.
   - Certificate as Registered Behavior Technician (RBT) **OR**
   - A letter signed by the KDADS HCBS Autism Waiver Program Manager or HCBS Director. This letter will validate the individual has met the alternative requirements for this enrollment:
     - An individual of 18 years of age or older
     - High school diploma or equivalent
     - 40 hours of successfully applied behavioral analysis training
       - 8 hours supervised intervention work
       - 3 hours ethics
       - At least one hour of each of:
         - Criterion of reference, social skills training, parent training, and program development

   This provider works under the direction of the BCBA or other qualified Consultative Clinical and Therapeutic Services (CCTS) practitioner. The worker will adhere to all state-approved standards, training, and ongoing requirements.

   The applicant should also demonstrate to KDADS of successful completion of an initial competency assessment. All annual training requirements must be met as specified by certification. Additionally, the Individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), APS, CPS, and nurse aide registry.

   Individuals who have met the requirements to be enrolled as a CCTS provider are deemed to have met the requirements to enroll as an IIS provider will need to request this specialty when enrolling.

8400. MEDICAID Updated 12/24

Children's Behavioral Interventions

Children's Behavioral Interventionist (CBI) services utilizing provider type/provider specialty (PT/PS) 11/130 can be reimbursed utilizing the following billing codes:

- H2018, per diem once per day. The intention is for this to be billed primarily in the home with child and family involvement and a minimum of 3 service hours recommended for the payment.
- H2017 with modifier U3 in 15-minute increments. The CBI model is based on intense work and therefore the expectation is for the service to be billed in no less than 3-hours per day. The use of the U3 modifier will require detailed documentation as to why the 3-hours wasn't met and is not to be used for tapering of the service. The intention is for this to be billed primarily in the home with child and family involvement. The service is limited to 12 units per day.

The goals of the intervention(s) will improve the family dynamic and the youth's emotional or behavioral disturbances. Although the CBI service is delivered through the behavior interventionist, for the integrity of the service delivery and to ensure involvement of the supervising entity, all service billing for codes H2017 U3 and H2018, will be performed by the supervising entity.

CBI Program Services:

CBI services are available to any individual based on a determination of medical necessity. These services are approved by a physician, advanced practice registered nurse (APRN), or other licensed behavioral health practitioner.

Service Definition:

CBI staff work in home where the child/youth reside. The CBI services provide child/youth with neuro-developmental activities for individuals/families that are struggling with behavioral and emotional management issues as established in a person-centered treatment plan. Assistance is provided with developing redirection skills and in the teaching of positive behaviors. This requires family involvement with the CBI provider modeling these skills. The active engagement of the CBI provider in neuro-stimulating activities assists in rewiring neuropathways in the brain. The goal is for the child/youth to live safely in the home setting and increase their behavioral function appropriately in daily living activities. These services are provided to assist in preventing hospital or institutional treatment.

Criteria for CBI Services:

- Child and Adolescent Functional Assessment Score (CAFAS) score of 71 or above
- Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of 71 or above
- Strengths and Difficulties Questionnaire (SDQ)

If the child/youth does not meet the criteria, the caregiver is notified and offered resources/services through the community providers.

Children's Behavioral Interventions continued

Admittance Process
Referrals are received through a variety of sources like private case managers, the Department for Children and Families (DCF), and self-referrals.

The Family Coordinator (FC) schedules and completes the referral triage and determines eligibility for services. Final approval for case opening is determined by Program Manager/Regional Director. Once approved, the FC completes the intake appointment. The FC will develop the Behavior Support Plan (BSP) in conjunction with information received from caregiver and case manager. The BSP will be signed off on by a Licensed Mental Health Professional (LMHP).

Provider Qualifications
CBI Program Manager/LMHP Qualifications:
Master's Degree in human services with 2 years' supervisory experience and 2 years' experience with children/youth with elevated behavioral needs. For purposes of elements with this service provision, a Licensed Behavior Analyst meets the LMHP criteria.

CBI Qualifications
An individual of twenty-one years of age or older with a high school diploma or equivalent, and 40 hours of successful in-house CBI training with a certificate of completion.

Training includes:

a. 12 hours of curriculum training including but not limited to trauma informed care, mental health diagnoses, behavioral strategies and interventions, impact of trauma on the brain and its development, understanding stress responses, building effective relationships with clients, gender issues, understanding neuro-stimulation activities and how it works, and role play scenarios.
b. 8 hours of Crisis Prevention Institute (CPI) training focused on de-escalation techniques.
c. 6 hours of CPR.
d. 6 hours of other training including mandated reporter, suicide prevention, documentation guidelines, and how to work with LGBTQ youth and families.
e. 8 hours of observed direct work with the client.

The above training curriculum is required for either licensed or unlicensed practitioners. A certificate of successful completion and DCF approval letter are required to be submitted with application materials. If the practitioner is not licensed, the supervising practitioner is required to submit an attestation and be kept on file. This CBI direct care provider will adhere to all state approved standards, meet all annual training and ongoing requirements as specified by certification while under the direction of the CBI Supervisor or other Qualified CBI Practitioner.

Children's Behavioral Interventions continued

This CBI direct care provider will adhere to all state approved standards, meet all annual training and ongoing requirements as specified by certification while under the direction of the CBI Supervisor or other Qualified CBI Practitioner.

Non-biller member of the intervention team will be the FC with the following qualifications: Bachelor's Degree in human service field with 2 years' experience or Master's Degree in human service field preferred, 2 years' experience with children/youth with elevated behavioral needs.

The FC is responsible for maintaining a relationship with the caregiver and any external stakeholders involved in the case i.e. foster care case management agency worker, GAL, CASA etc. The FC completes the initial intake assessments and triages the client to determine eligibility for the CBI program. The FC is responsible for completing all required subsidy paperwork to funding sources as well as completing quarterly assessments. The FC participates and advocates on behalf of the family when the client is matched with a potential CBI. It is the FC's responsibility to have a good working knowledge of the family/client's strengths, needs, preferences and deal breakers when it comes to initiating a partnership between the CBI and the family. The FC is also responsible for maintaining open communication between the CBI program and the client/family/caregivers. The FC should be reaching out to the family at minimum twice per month, offering support or checking in, looking for additional referrals or wraparound services that can be offered.

Position Definition/Roles:

Below are the key positions and associated responsibilities within the CBI program.

Regional Director

- Provides direct program supervision, human resource oversight, program planning and implementation, quality assurance oversight, and staff training to the behavioral interventionist and program.
- Responsible for employee satisfaction within the program and strives to build a sense of team.
- Conduct individual supervisory conferences with the behavior interventionists and family coordinators at least bi-monthly with the goal of providing continual support, guidance, and work product evaluation/feedback.
- Responsible for identifying the training needs and professional development needs of staff supervised.
- Ensure families served are given proper support and advocacy.
- Maintain contact and relationship building with other partner agencies and community stakeholders.
- Occasionally travel to attend and/or present in-service training, to conduct behavioral interventionist training/presentations and to complete assessments on clients as needed or assigned.
- Responsible for recruiting behavioral interventionist staff and increase program referrals.
- Attend trainings, court and meetings as required and actively participate in all leadership meetings.

Children's Behavioral Interventions continued

- Contribute on an organizational level with a focus on agency culture, cultural competency, and performance improvement outcomes.
- Monitor and ensure billing is completed in a timely manner.
- Oversee relevant funding needs.

Program Manager

- Provides oversight to meet the specified outcomes for the program.
- Responsible for caregiver satisfaction within the program.
- Supports caregivers through advocacy and working with family coordinators.
- Provides supervision and leadership to increase performance and leadership skills.
- Responsible for employee and team satisfaction within the program.
- Responsible for monitoring the workload of all family and behavior interventionist coordinators.
- Conducts individual supportive supervisions with all family and behavior interventionist coordinators.
- Completes timely probationary and annual employee evaluations.
- Ensures all initial and annual training requirements are met.
- Maintains and monitors client referrals and waitlists.
- Reviews and approves incident reports and client documentation monthly.
- Works with other departments to ensure payroll is completed timely.
- Tracks program hours and ensures funding criteria is being met.

Family Coordinator

- Schedules and completes all family meetings.
- Completes all client and caregiver assessments with the family.
- Writes and submits recommendation, approval, and renewal letters for services.
- Develops the client's behavioral plan and updates it quarterly.
- Communicates with family and the client's professional team.
- Assists in facilitating new hire training curriculum.
- Collaborates with leadership in matching behavior interventionists to homes.
- Conducts and facilitates Meet and Greet meetings.
- Maintain a caseload of up to 20-25 families.
- Tracks behavior interventionists missed shifts and follows up with family as needed.
- Uploads all documents to spreadsheets/ database in a timely manner.
- Completes aftercare follow-up.

BI Coordinator

- Provides direct supervision and support for up to 20 behavior interventionists.
- Weekly supervision the first month of employment; monthly thereafter.
- Completes Observation Shifts in the homes quarterly.
- Schedules shadow shifts for new hires.
- Reviews behavior interventionist shift notes daily for completion and audits monthly.
- Assists in facilitating new hire training curriculum.

Children's Behavioral Interventions continued

- Tracks behavior interventionist missed shifts and approves/monitors their PTO.
- Ensures behavior interventionist documentation is completed on time.
- Makes certain that behavior interventionist hours worked matches documentation and payroll.
- Ensures behavior interventionist complete and get compensated for trainings, meetings, supervisions, and documentation.
- Assists with interviews and the behavior interventionist hiring process.
- Collaborates with family coordinators to assist in the matching behavior interventionist to homes.
- Reviews and approves behavior interventionist mileage reimbursement.

Hiring Coordinator

- Works with HR to recruit and seek out qualified candidates for the behavior interventionist position.
- Schedules and completes phone screenings, interviews, and employment references of candidates.
- Works with behavior interventionist coordinators to schedule interviews.
- Tracks the hiring and onboarding steps of each resume/candidate.
- Ensures newly hired behavior interventionist complete each step of the onboarding process.
- Works closely with family and behavior interventionist coordinators in matching behavior interventionist with clients.
- Schedules and facilitates behavior interventionist orientation.
- Schedules and assists in facilitating curriculum.
- Responsible for obtaining/maintaining instructor and training certification to provide required trainings to BIs as applicable.

Behavioral Interventionist 1 (part-time)

- Responsible for working one-on-one with the client.
- Creates and implements neuro-stimulating activities.
- Works with the client and family to implement positive reinforcement in daily living activities.
- Provides direct supervision to client at all times.
- Provides direction, coaching, and approved intervention strategies.
- Keeps the client and others safe from the client's behaviors.
- Adheres and follows the client's behavioral plan.
- Builds and maintains strong rapport with client and client's caregivers.
- Maintains strong communication with their supervisor and caregivers.
- Completes all documentation in a timely manner.
- Completes, maintains, and ensures utilization of their training.

Community Health Worker Services

Kansas Medicaid will provide reimbursement for services provided by a Community Health Worker (CHW) for the following codes:

98960	98961	98962

Community Health Worker Services continued

A CHW is an individual certified in the State of Kansas to provide services within the scope of the certification program. Supervision of the certified CHW is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified CHW and attest to the CHW's certification. Each supervising licensed practitioner shall bill for the services of the certified CHW.

Coverage Parameters and Limitations

Kansas Medicaid will apply the following parameters and limitations to covered CHW services:

- Services Must be provided face-to-face with the member, individually or in a group, in an outpatient home, clinic, or other community setting. Services are limited to 4 units (or 2 hours) per day, per member.
- Services are limited to 24 units (or 12 hours) per month, per member.

Billing Instructions:

The services must be billed using the individual or individual group member National Provider Identification (NPI). These services are not reimbursable to a Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), or Indian Health Center (IHC). If the RHC/FQHC/IHC shares an NPI with the physician group, reimbursement should be to the physician group only.

When billing these services, providers must append modifier U7 to codes 98960, 98961, and 98962 to indicate the CHW has met the required training requirements and has received a certificate of completion. The billing provider must maintain documentation of CHW certification and background checks for the individual providing the CHW services.

Community Health Worker Qualification

To provide CHW services to members under Kansas Medicaid, a CHW must be certified through a CHW certification recognized by the Kansas Department of Health and Environment (KDHE). Applicants may apply for certification through one of two pathways listed below and must complete KDHE approved CHW training or work experience requirements. Please choose only one pathway option:

Education Pathway*:* Applicant must complete the KDHE approved CHW training program through the Kansas CHW Coalition or certified Kansas CHW education provider.

Work Experience Pathway: Applicant must complete 800 hours over three years plus three letters of recommendation to document work and/or volunteer experience.

The CHW services shall include:

- Screening and assessment to identify health-related social needs and barriers to accessing health care.
- Health promotion and coaching to assist members to set goals and action plans to address health-related social needs and barriers to accessing health care; and provide information, coaching, and support to assist members to engage and re-engage in their own health care including adherence to treatment plans, follow up with necessary health care, and self-management of chronic conditions.

Community Health Worker Services continued

- Health system navigation and resource coordination and groups of members, consistent with established or recognized health care standards, on methods and measures to prevent disease, disability, and other health conditions or their progression.
- Care planning with a member's care team to support a person-centered holistic approach to care delivery to promote physical and mental health and efficiency, and to address health-related social needs and barriers to accessing health care.

These services may be provided in the community, in a clinic setting, individually or in a group.

Collaborative Care Model

Effective with dates of service on or after January 1 2025, the Collaborative Care Model (CoCM) services provided to Medicaid eligible members for persons of all ages who have any mental health or substance use condition, to include a preexisting or suspected mental health or substance use condition, who meets medical necessity as determined by the primary care provider practicing within their scope of service (physician, physician assistant, nurse practitioner or nurse midwife).

CoCM services are systematic, integrated services provided by a team, individually delivered, time-based, monthly services. Teams should include the following: Treating (Billing) Practitioner, Behavioral Health Care Manager (BHCM), Psychiatric Consultant, and the member. CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to meet targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

The following service codes are used to bill the CoCM services:

<table>
<tr><th>Procedure Code</th><th colspan="2">Benefit Limit</th></tr>
<tr><td>99492</td><td>One per 365 days (same provider)</td><td rowspan="3">Codes 99492, 99493, and G2214 are limited to one combined unit per month</td></tr>
<tr><td>99493</td><td></td></tr>
<tr><td>G2214</td><td></td></tr>
<tr><td>99494</td><td>Two per month</td><td></td></tr>
<tr><td>G0323</td><td></td><td></td></tr>
</table>

CoCM services provided under the direction of the primary care provider include but are not limited to:

- Initial assessment by the primary care team (billing practitioner and BCHM).
- Initiating visit (if required, separately billed).
- Administration of validated rating scales(s).
- Care planning by the primary care team, jointly with the beneficiary, with care plan revisions for patients whose care is not improving adequately.
- Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments.

Collaborative Care Model continued

The BHCM performs proactive, systemic follow-up using validated rating scales and a registry, assesses treatment adherence, tolerability, and clinical response using validated rating scales; delivers brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing.

Regular case load review with psychiatric consultant:

The primary care team regularly (at least weekly) reviews the member's treatment plan and status with the psychiatric consultant. The primary care team maintains or adjusts treatment, including referral to behavioral health specialty care, as needed.

Claims processing:

- Only the primary care provider may submit claims for CoCM services. The BHCM and psychiatric consultant are reimbursed by the primary care provider via a contract, employment, or other arrangement. These services are considered incident to the billing provider's services.
- Primary care providers providing CoCM services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) setting shall submit claims under their Professional National Provider Identifier (NPI). CoCM claims will be denied if submitted under the FQHC or RHC entity NPI.

Covered Provider Type/Provider Specialties:

PT/PS	Description
09/093	Advanced Registered Nurse Practitioner
09/095	Certified Nurse Midwife
09/096	Psychiatric Nurse Practitioner
10/100	Physician Assistant
31/000	All Physician Specialties

Professional Providers in accordance with state law shall be:

1. Licensed in their appropriate discipline
2. Enrolled in KMAP
3. Review Contract with KanCare MCO as applicable

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)

Effective with dates of service on or after January 1, 2026, the use of Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) can be applied to children from birth to five (5) years old.

The following codes shall be used in the amount and frequency to thoroughly assess KAN Be Healthy (KBH) members, based upon members' individual needs and ability to participate in testing/assessment.

96112	96113

For additional information, refer to *Kan Be Healthy – Early and Periodic Screening, Diagnostic and Treatment Provider Manual*, Section: **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)**.

8400. MEDICAID Updated 04/26

Maternal Depression Screenings

Note: For specific instructions, reference the *Professional Fee-for-Service Provider Manual* on the Provider Manuals page.

Opioid Use Disorder Treatment – Opioid Treatment Programs

All Opioid Use Disorder Treatment drugs and biological products used for Opioid Use Disorder (OUD) will be covered. OUD Treatment is the combination of medications, counseling, and other behavioral interventions for OUD. No prior authorization is required for the services listed in this policy update. However, providers are responsible for ensuring full compliance with all applicable requirements prior to claim submission.

Counseling requirements under the Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs are established in accordance with the statutory authority granted to KDADS for Substance Use Disorder (SUD) services, as outlined in K.S.A. 65-4001 et seq.

All OUD Treatment drugs and biologicals billed through the medical benefit require a diagnosis code to be considered for payment.

Medications Covered:

OUD Treatment drugs used for OUD are considered Part B drugs, per Medicare guidelines. The following drugs are covered OUD Treatment drugs for Opioid Treatment Program (OTP):

- Buprenorphine brand products and their associated generics:
  - Buprenorphine sublingual tablets (Subutex)
  - Buprenorphine/naloxone sublingual films (Suboxone)
  - Buprenorphine/naloxone) sublingual tablets (Zubsolv)
  - Buprenorphine/naloxone buccal film (Bunavail)
  - Buprenorphine implants (Probuphine)
  - Buprenorphine extended-release injection (Brixadi)
  - Buprenorphine extended-release injection (Sublocade)
- Methadone
- Naltrexone brand products and their associated generics:
  - Naltrexone tablets (Depade, Revia)
  - Naltrexone injection (Vivitrol)

Provider Information:

Collaboration and documentation between the OTP and other providers assisting with related OTP services is required to coordinate services included in codes that are a bundled service.

Opioid Use Disorder Treatment – Opioid Treatment Programs continued

Opioid treatment providers are required to be enrolled in Medicare as an OTP provider. Verification of Medicare enrollment is required. Providers who are enrolled as a Medicare provider for OTP and enroll as a Medicaid provider will be exempt from the Medicaid enrollment fee. Medicaid dual eligible information can be found here.

All licensures must be in accordance with Medicare standards.

Approved Providers:

Allowed Practitioners will be those individuals employed in a licensed Substance Use Disorder (SUD) program as allowed by State Licensing regulations and/or standards and licensed to prescribe and/or dispense medications for opioid use disorders.

Authorized OTP Practitioner:

An Authorized OTP Practitioner is defined as: "A health care professional who is appropriately licensed by a State to prescribe and/or dispense medications for opioid use disorders."

OTPs must ensure adequate provision or referral of the following services:

- Medical care
- Counseling
  - Covered counseling services may include but are not limited to:
    - Psychoeducational services
    - Harm reduction and recovery-oriented services
    - Referrals for positive results related to HIV, hepatitis, sexually transmitted infections (STIs), or OTP-provided medical examinations
- Vocational and educational services
- Other assessments and treatment services
- Services not provided onsite must be referred to an external provider or agency.

Coding for OUD Treatment and Add on Codes:

The threshold for billing the codes describing weekly episodes, HCPCS codes G2067-G2075, is the delivery of at least one service in the weekly bundle (either the drug or non-drug component). If no drug was provided to the patient during the episode, the OTP must bill the G-code describing a weekly bundle does not include the drug (G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

CMS established HCPCS G-codes describing treatment with:

- Buprenorphine injectable (G0533)
- Coordinated care and/or referral services (G0534)
- Patient navigational services (G0535)
- Peer recovery support services (G0536)
- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)

Opioid Use Disorder Treatment – Opioid Treatment Programs continued

CMS established HCPCS G-codes describing treatment with continued:

- Buprenorphine implants (insertion, removal, and insertion/removal) (G2070, G2071, and G2072)
- Extended-release, injectable naltrexone (G2073)
- Non-drug bundle (G2074) bill for services furnished during an episode of care when a medication is not administered. For example, in the case of a patient receiving injectable buprenorphine, we would expect that OTPs would bill HCPCS code G2069 for the week during which the injection was administered and you would bill HCPCS code G2074, which describes a bundle not including the drug, during any subsequent weeks when you furnish at least one non-drug service until you administer the injection again, at which time, you would bill HCPCS code G2069 again for that week.
- Medication not otherwise specified (G2075) - Use when you give OUD Treatment services with a new opioid agonist or antagonist treatment medication approved by the Food and Drug Administration (FDA) under Section 505 of the United States Federal Food, Drug, and Cosmetic Act (FFDCA) for the treatment of OUD.
- Intake activities (G2076)
- Periodic assessments (G2077)
- Additional counseling furnished (G2080)
- Take-home supplies of: (These are add-on codes. List separately in addition to each primary code.)
    - Nasal nalmefene hydrochloride (G0532) (one carton of two, 2.7 mg per 0.1 mL nasal sprays
    - Nasal naloxone (G1028) (2-pack of 8 mg per 0.1 mL nasal spray)
    - Methadone (G2078)
    - Oral buprenorphine (G2079)
    - Nasal naloxone (G2215)
    - Injectable naloxone (G2216)

Frequency of use and other billing guidelines:

- G2067 – G2075 may not be billed more than once per 7 days.
- G2069 and G2073 may not be billed more than once every 4 weeks.
- G2070 and G2072 may not be billed more than once every 6 months.
- G2076 should only be billed for new patients. (No specific direction for this code currently).
- G2078 or G2079 may not be billed with more than 3 units. Substance Abuse and Mental Health Services Administration (SAMHSA) allows a maximum take-home supply of one month of medication; therefore, we do not expect the add-on codes describing take-home doses of methadone and oral buprenorphine to be billed any more than 3 times in one month (in addition to the weekly bundled payment).
- G2078 may only be billed with G2067.
- G2079 may only be billed with G2068.
- G2080 may be billed when counseling or therapy services are furnished that exceed the amount specified in the patient's individualized treatment plan. OTPs are required to document the medical necessity for these services in the patient's medical record.

Opioid Use Disorder Treatment – Opioid Treatment Programs continued

Frequency of use and other billing guidelines continued:

- Codes G2067 through G2075 may not be billed within the same 7-day period. When a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.
- G2067 or 80358 cannot be billed within the same 14 days.
- G2067 or G2078 AND 83840 or H0020 or S0109 cannot be billed in the same week.
- G2080 AND H0004 or H0005 cannot be billed within the same week.
- H0004 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0005 or H0005 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0006 or H0006 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0015 or H0015 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- G2068 or 80348 cannot be billed within the same 14 days of each other.
- G2068 or G2079 AND J0571 or J0572 or J0573 or J0574 or J0575 cannot be billed within the same week.
- G2073 and J2315 cannot be billed within the same 4 weeks.
- G2069 AND Q9991 or Q9992 cannot be billed within the same 4 weeks.
- G2080 and H0004 should not be billed within the same week.
- G2070, G2071, G2072 and J0570 cannot be billed more than 2 times within 12 months and no more than 2 billings per patient, per current FDA approval of this drug.
- G2070 or G2072 and J0570 cannot be billed within the same 6 months.
- G2071 and G2072 cannot be billed within the same 6 months.
- G2070 and G2071 can only be billed once within the same 12 months as G2072
- H0001 should not be billed by an OTP.
- G2075 requires manual review.
- G1028, G2215, and G2216 may only be billed once every 30 days unless an additional take-home supply of the medication is medically reasonable and necessary.
- G2216 should be billed with the dosage dispensed in the unit's field (Box 24G of the CMS-1500 form), rounded to the nearest whole number (minimum dosage: 1 mg).
- G0137 (add-on code) can be used to cover episodes of care lasting 7-days in a row
  - Don't bill if the patient does not receive at least 9 IOP services in a week.
  - Don't bill if the patient does not have a need for a minimum of 9 hours of IOP services a week.
  - Don't bill if the patient does not require a higher level of care intensity compared to other non-intensive outpatient OTP services.

Opioid Use Disorder Treatment – Opioid Treatment Programs continued

Date of Service

For the codes that describe a weekly bundle (G2067-G2075), one week is defined as 7 contiguous days. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a member starts treatment at the OTP on a day that is in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care provided that the threshold to bill for the code has been met.

Alternatively, OTPs may choose to adopt weekly billing cycles that vary across patients. Under this approach, the initial date of service will depend upon the day of the week when the patient was first admitted to the program or when Medicare billing began. Under this approach of adopting weekly billing cycles that vary across patients, when a patient is beginning treatment or re-starting treatment after a break in treatment, the date of service would reflect the first day the patient was seen and the date of service for subsequent consecutive episodes of care would be the first day after the previous 7-day period ends.

For the codes describing add-on services (G2076-G2080), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle.

Covered Place of Service Codes

- 58 – Non-Residential Opioid Treatment Facility – A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of OUD Treatment.
- 15 – Mobile Unit – OTPs which have a Drug Enforcement Administration (DEA) approved mobile unit, will be reimbursed for delivery of Methadone to patients. A current agreement for approval to provide mobile unit service with the Drug Enforcement Agency is required. All requirements of the agreement and licensure thereof must be adhered to and are auditable.

Telehealth and transportation codes are covered codes for OTP services. Please refer to the Kansas Medicaid Telehealth and Non-Emergency Medical Transportation (NEMT) policies.

Current rules for other health insurance apply. Providers of this type of service are required to bill claims to primary insurance, if applicable.

For presumptive and definitive urine drug screens, no fewer than eight (8 random drug tests per year will be allowed from the same OUD Treatment provider (80348 and 80358) unless extenuating circumstances apply. Compliance may be reviewed retrospectively.

8400. MEDICAID Updated 04/26

Opioid Use Disorder Treatment – Office Based Opioid Treatment (OBOT) Programs

OUD Treatment drugs, excluding Methadone, will be covered for OBOT, according to the inclusions and exceptions listed below. Methadone used for OUD Treatment is only covered in an OTP setting. OUD Treatment drugs used for OUD are considered Part B drugs, but OUD Treatment drugs dispensed at the pharmacy and delivered to an OBOT provider are covered under Medicare Part D. If an OBOT provider purchases an OUD Treatment product and administers it to the patient in the provider setting, this would be a physician-administered drug covered under Medicare Part B.

Covered drugs and biological products approved for OBOT are listed below and providers should follow the laws and guidelines for providing OBOT. More information can be found here.

Buprenorphine products indicated for OUD Treatment are the following:

- Buprenorphine brand products and their associated generics:
  - Buprenorphine sublingual tablets (Subutex)
  - Buprenorphine/naloxone sublingual films (Suboxone)
  - Buprenorphine/naloxone) sublingual tablets (Zubsolv)
  - Buprenorphine/naloxone buccal film (Bunavail)
  - Buprenorphine implants (Probuphine)
  - Buprenorphine extended-release injection (Brixadi)
  - Buprenorphine extended-release injection (Sublocade)
- Naltrexone brand products and their associated generics:
  - Naltrexone tablets (Depade, Revia)
  - Naltrexone injection (Vivitrol)

Buprenorphine products that are indicated for pain, such as Belbuca, Butrans, and Buprenex, should not be prescribed for OUD Treatment.

Physicians, nurse practitioners, physician assistants, and qualified mid-level practitioners may dispense or prescribe any Controlled Substances Act (CSA) scheduled III, IV, V medication approved by the Food and Drug Administration (FDA) for the treatment of Opioid Use Disorder (OUD). Kansas Medicaid will no longer require the DATA Waiver (X-Waiver) to be obtained and submitted for verifications, by the provider, before prescribing medications for the treatment of OUD. More information can be found here.

Clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives are included in the provider types approved for OUD Treatment services, per the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. More information can be found here.

Opioid Use Disorder Treatment – Office Based Opioid Treatment (OBOT) Programs continued

Services Covered:

The SUPPORT Act requires counseling and behavioral therapy to be part of an OUD Treatment program. Coordination of these services is necessary to ensure services are rendered and proper billing occurs. Compliance with the K.S.A. 39-708c, 65-4016, and 65-4607.

"Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs" R03—711, Section K, regarding counseling requirements is required:

The following codes are covered:

80348	G2086	G2087	G2088	H0001	H0004
H0005	H0005 U5	H0006	H0006 U5	H0007	H0015
H0015 U5	J0570	J0571	J0572	J0573	J0574
J0575	J0577	J2315	Q9991	Q9992	

*J0592 refers to buprenorphine injections for pain only, not OUD.

For presumptive and definitive urine drug screens, no more than 24 tests cumulative per patient per rolling year will be allowed from the same OUD Treatment provider (80348 and 80358). Medication use counseling for OUD medications that is provided by pharmacists are not included as part of OBOT services.

Current rules for other health insurance apply. Providers of this type of service are required to bill claims to primary insurance, if applicable.

All licensures must be in accordance with Medicare standards.

Eating Disorder Care

Effective with dates of service retroactive to January 1, 2025, the Partial Hospitalization Psychiatric Care (PHP) and Intensive Outpatient Treatment (IOP) for Eating Disorder Care shall be provided by providers enrolled with KMAP to individuals meeting medical necessity, with a mental health diagnosis for an eating disorder.

Covered Services

Coverage provided is limited to medically necessary treatment that is provided under the direction of a licensed treating physician and in accordance with a treatment plan. Services shall be provided for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.

The following are the covered services and must be billed with allowable diagnoses listed below.

Visit Type	Code	Benefit Limits
PHP Care	H0035	– Maximum one unit per day (One unit of service is a one-day session). – Maximum five days per week (Minimum of 20 hours per week).
IOP Treatment for Eating Disorder Care	S9480	– Maximum one unit per day (One unit of service is a one-day session).

8400. MEDICAID Updated 04/26

Eating Disorder Care continued

Allowable Mental Health Diagnoses for Eating Disorder:

The care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with an eating disorder, shall not be based solely on weight, and preserves the patient's dignity to the greatest extent possible.

The following diagnosis should be associated to individuals receiving care and of which may be co-occurring.

Diagnosis Type	Diagnosis Code Range
Eating Disorder	F50.00 - F50.29 (Anorexia nervosa) F50.2 - F50.25 (Bulimia nervosa) F50.8 - F50.9 (Other eating disorders)

Covered Provider Types/Provider Specialties

The following are the covered provider type/provider specialties (PT/PS):

PT/PS	Specialty Description
01/011	Psychiatric Hospital
11/**021***	PHP Care/IOP Treatment

*Mental health providers should enroll under new specialty **021** using taxonomy **261QM0801X**.

Enrollment Requirements for Specialty 021

- Organizations shall hold a National Accreditation from a *one of* these nationally recognized entities with a Behavioral Health Accreditation attachment.
  - The Joint Commission (TJC) or
  - Commission on Accreditation of Rehabilitation facilities (CARF)
- Enrolled and credentialed as a Kansas Medicaid Provider.
- Form W-9.
- Organizations shall ensure all professional staff are licensed in the State of Kansas and all paraprofessional staff are appropriately certified and trained.

Billing Guidelines

- Psychiatric hospitals (specialty 011) may bill for PHP or IOP services using its existing taxonomy codes: 273R00000X (Hospital Units/Psychiatric Unit) or 283Q00000X (Hospitals/Psychiatric Hospital).
- Mental health providers (specialty 021) may bill for PHP or IOP services using taxonomy code 261QM0801X (Ambulatory Health Care Facilities/Clinic/Center/Mental Health [including Community Mental Health Center]).

Eating Disorder Care continued

- PHP Care – Code H0035:
  - Allowed one unit per day.
  - A maximum of 5 days shall be billed per week services for a minimum of 20 hours per week and would require inpatient psychiatric care if the partial hospitalization services were not provided.
- IOP Treatment – Code S9480:
  - Allowed one unit per day.
  - A minimum of 2 service components (refer to core components section below) per session to achieve 9 to 19 hours of intervention per week for adults (18 yrs. +) and 6 to 19 hours of intervention per week for youth (ages 6-17 yrs).
- Services not reimbursable with IOP services.
  - Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0: H0005 U5, H0004, H0018, H0015 U5, H0019
  - Opioid Based Outpatient Treatment Services: 80348, G2086, G2087, G2088, H0005, H0001, H0005 U5, H0006, H0006 U5, H0004, H0015 U5, H0007, J0570 J0571, J0572, H0015, J0575, J0573, J2315, Q9991, J0574
  - Psychosocial Rehabilitation: H2017, H2017TJ, H2017HQ
  - Assertive Community Treatment: H0040
  - Psychiatric Residential Treatment: T2048
  - Inpatient admissions

Note: Providers may submit a claim for:

- Psychiatric evaluation services 90791 or 90792 when provided by qualified professional staff when an individual does not meet program admission criteria.
- Crisis Psychotherapy 90839 and 90840 when provided outside of program hours to an individual of the program.

Noncovered Services

The following are not covered:

- Meals and transportation,
- Activity therapies,
- Group activities or other services and programs which are primarily recreational or diversional in nature.
- Outpatient psychiatric day treatment programs that consist entirely of activity therapies.

Staffing Ratios:

Staffing should not exceed one staff member per five individuals in the program. Clinical supervision of staff should not exceed one supervisor for six direct care workers.

Eating Disorder Care continued

Core Service Components

Core Components should include:

1. Screening, intake, and assessment services.
2. Referral services.
3. Emergency psychiatric services.
4. Emergency and routine medical services.
5. Physician services.
6. Nursing services.
7. Psychotherapy services (Individual/ Group/Family); and
8. Dietary services.

Treatment Plan

- Services shall be based on a comprehensive, coordinated, and individualized treatment plan, services shall involve the use of multiple, concurrent interventions and treatment modalities.
- Address the underlying causes of the eating disorder, develop coping skills, promote recovery, and reduce the need for a more acute level of care.
- Core services shall be available to individuals on a daily basis, either as part of routine or emergency care.
- ***The treatment plan shall include, but is not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals***.

Recertification Requirements PHP

The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. The first recertification is required as of the 18th day of partial hospitalization services. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days. The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:

A. The patient's response to the therapeutic interventions provided by the partial hospitalization program.
B. The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization.
C. Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program.

Eating Disorder Care continued

Recertification Requirements IOP:

The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. Recertifications are required at intervals established by the provider, but no less frequently than every 60 days. The recertification must specify that the patient continues to require at least 9 hours of intensive outpatient services and describe the following:

A. The patient's response to the therapeutic interventions provided by the intensive outpatient program.
B. The patient's psychiatric symptoms that continue to place the patient at risk of relapse or hospitalization.
C. Treatment goals for coordination of services to facilitate discharge from the intensive outpatient program.

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs Updated 10/24

Community-Based Services Team Meeting

This service provides a forum where an individual, family caregivers, providers, and engaged community representatives can meet to discuss recommendations for treatment needs, which may include a recommendation for inpatient treatment.

Mental Health Assessment

This service can be provided by a nonphysician at a professional level. Code H0031HO is reimbursed per session.

Psychiatric Residential Treatment Facility Clinical Requirements

A request for a higher level of care at a PRTF must be evaluated as a medical necessity. This request will use both the Community Based Services Team (CBST) meeting, as well as the Psychiatric Diagnostic Evaluation. The Psychiatric Diagnostic Evaluation will be conducted face-to-face with the child/youth using the approved methods.

Limitations/Exclusions

- H0032-HA can be billed on the same day as 90791 or 90792
- H0031 specific to ages 0-8

Service Codes:

H0031	H0032	H0032HA

Psychiatric Diagnostic Evaluation Codes:

90791	90792

Note: Codes 90791 and 90792 can only be billed once per day, and both codes cannot be billed on the same day.

PROVIDERS*

Allowed providers

- **Licensed Mental Health Professional (LMHP)** – An individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license.
  - LMHP providers licensed to practice independently:
    - Licensed psychologist
    - Licensed clinical marriage and family therapist
    - Licensed clinical professional counselor
    - Licensed specialist clinical social worker
    - Licensed clinical psychotherapist
  - LMHP providers licensed to practice under supervision or direction:
    - Licensed Masters level marriage and family therapist
    - Licensed Masters level professional counselor
    - Licensed Masters level social worker
    - Licensed Masters level psychologist

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs Updated 07/25

PROVIDERS* continued

- **Qualified Mental Health Professional (QMHP)** – A Master's level clinician licensed by the Kansas Behavioral Sciences Regulatory Board and employed by a CMHC, an individual holding a medical degree, or an advanced practice registered nurse (APRN).
- A physician, physician assistant, or an advanced practice Nurse Practitioner working under protocol of a physician
- Non-licensed mental health service providers
  Note: Specific provider qualifications are noted with the associated service.

****Mental Health Services for Nursing Facility for Mental Health Recipients of Services**

The State of Kansas provides the following state-funded services to individuals residing in a nursing facility for mental health (NF/MH):

- **Annual Screen**
  - The annual screen for continued stay for individuals residing in an NF/MH (T2011) is completed to determine the individual's continued need for this level of care. The annual screen is a scheduled face-to-face interview with the individual by a trained CMHC screener and a screening facilitator who are registered with KDADS Behavioral Health Services (BHS) Commission.
  - Procedure code T2011 is covered if services are provided in NF/MH.
  - Additional information should be gathered from other sources including the guardian/family member, treatment staff, and other informants. A review of the facility chart should be made, and pertinent information included on the screening tool. Payment for annual screens requires prior authorization by KDADS BHS staff following established guidelines and protocols for this process and are communicated to the fiscal agent. Payment is for one screen per individual per year.

Note: CCBHC providers please also reference the KMAP CCBHC Provider Manual.

Other services provided to individuals residing in an NF/MH include:

- **Therapy**
  - Up to eight hours of Individual Therapy for individuals in acute trauma and up to four hours per year for Diagnostic Admission Evaluation are allowed.
- **Targeted Case Management**
  - Codes T1017 and H0036HB may be provided during the 120 days prior to discharge.
  - Targeted Case Management is provided by CMHC staff who have completed training approved by KDADS BHS.
    Note: For specific instructions, reference the *Targeted Case Management – Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page.
- **Personal Care Services**
  - Up to 180 hours of code T1019HE may be provided per individual per calendar year for up to 60 days prior to discharge.
  - Personal Care Services (Attendant Care) may be provided when a screen for continued stay in an NF/MH has been completed and approved by KDADS BHS
  - within the last calendar year with a recommendation of "discharge" and under the following additional conditions:
    - A treatment plan has been developed with a goal of "community integration".
    - Personal Care Services are provided in the intended discharge community.

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs Updated 10/24

****Mental Health Services for Nursing Facility for Mental Health Recipients of Services continued**

- Personal Care Services provide one-to-one support or supervision for individuals transitioning from an NF/MH to community living and facilitate identification of needed services and supports an individual will require to live in the community.
- Personal Care Services are provided by CMHC staff who have completed Attendant Care training approved by KDADS BHS.

Specialized Community-Based Rehabilitation Services

Community-Based Psychiatric Rehabilitation Services are of a comprehensive specialized psychiatric program available to all KMAP service recipients with significant functional impairments resulting from an identified mental health diagnosis or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by an LMHP or physician who is acting within the scope of his or her professional license and applicable state law. The services must be furnished by or under the direction of a physician to promote the maximum reduction of symptoms or restoration of an individual to his or her best possible functional level.

Services must be medically necessary, must be recommended by an LMHP or physician according to an individualized treatment plan, and must be furnished under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives.

Services provided at a work site must not be job-task oriented. Services provided in an educational setting must not be educational in purpose. Any services or components of services of which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, childcare, and laundry services) are noncovered. Services, other than those described in the **Mental Health Services for Nursing Facilities for Mental Health Recipients of Services** section above, may not be provided in an IMD.

Required Trainings for Specialized Community-Based Rehabilitation Services

- Training Requirements and Approved Training is located at: KDADS.KS.Gov- Providers-Training.
- Providers should create a Kansas Train account. Those instructions can be found in the Supplemental Online Training page, under the Kansas Train Instructions

Note: Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for complete details regarding Telemedicine for the Specialized Community Based Rehabilitation services listed below.

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs Updated 10/24

Specialized Community-Based Rehabilitation Services continued

For these Specialized Community-Based Rehabilitation services, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Peer Support (PS), Crisis Intervention (CI), and Mobile Crisis Intervention (MCI), the following enrolled supervising Provider Type/Provider Specialties (PT/PS) will be allowed when billed as the rendering provider:

PT/PS	Description
09/093	Nurse Practitioner (Other)
09/096	Psychiatric Nurse Practitioner

PT/PS	Description
10/100	Physician Assistant

PT/PS	Description
11/108	Licensed Master's Level Psychologist (LMLP)
11/109	Licensed Clinical Psychotherapist (LCP)
11/111	Community Mental Health Center (CMHC)
11/112	Psychologist
11/115	Licensed Mental Health Professional (LMHP)
11/116	Licensed Clinical Mental Health Professional (LCMHP)
11/121	Certified Community Behavioral Health Clinic (CCBHC)
11/123	Children with Severe Emotional Disturbances
11/125	Home Based Family Therapy
11/176	Alcohol and Drug Rehabilitation

PT/PS	Description
31/316	Family Practitioner
31/318	General Practitioner
31/339	Psychiatrist
31/348	Addiction Medicine
31/349	Exempt License Physician

1. **Community Psychiatric Support and Treatment (CPST)** is goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the service recipient's individualized treatment plan. CPST is a face-to-face intervention with the service recipient present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

Specialized Community-Based Rehabilitation Services – CPST continued

CPST may include the following components

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living; financial management; housing; academic and/or employment progress; personal recovery or resilience; family and/or interpersonal relationships; and community integration.
- Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.
- Participate in and use strengths-based planning and treatments, which include assisting the individual and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; and to use personal strengths, resources, and natural supports to address functional deficits associated with the individual's mental illness.
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk the individual remaining in a natural community location, including assisting the individual and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or (as appropriate) seek other supports to restore stability and functioning.

Provider qualifications:

- BA/BS degree or four years of equivalent education and/or experience working in the human services field
- Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Completion of a training program approved by KDADS

To bill CPST, submit the following procedure codes and modifiers*:

H0036HA	Child (21 years or under)	H0036HB	Adult (16 years or over)

Note: If clinical reasons are present that support an individual under the age of 4 or over the age of 18 would benefit from services provided as an individual or in a group setting utilizing "child/youth" services, billing justification for this clinical decision should be documented in the medical record. If an individual 18 years of age or under would benefit from services provided as an individual or in a group setting utilizing "adult" services, this clinical decision should likewise be documented in the medical record.

Service limitations ratio:
Caseload size must be based on the needs of the clients and families with an emphasis on successful outcomes and client satisfaction and must meet the needs identified in the individual treatment plan. The following general ratio should serve as a guide:

- 1 full-time equivalent (FTE) to 15 youth clients
- 1 FTE to 25 adult clients

2. **Psychosocial Rehabilitation (PSR)** services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with the individual's mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

PSR may include the following components:

- Restore and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, and develop coping strategies and effective functioning in the individual's social environment including home, work, and school.
- Restore and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with an individual's daily living.
- Support the individual with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
- Implement learned skills so the individual may remain in a natural community location.
- Assist the individual to effectively respond to or avoid identified precursors or triggers that result in functional impairments.

Provider qualifications

- Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Must have a high school diploma or equivalent
- Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a training program approved by KDADS

Specialized Community-Based Rehabilitation Services – PSR continued

To bill PSR, submit the following procedure codes and modifiers:

H2017	Individual	H2017TJ	Child Group (21 years or under)	H2017HQ	Adult Group (16 years or over)

Note: If clinical reasons are present that support an individual under the age of 4 or over the age of 18 would benefit from services provided as an individual or in a group setting utilizing "child/youth" services, billing justification for this clinical decision should be documented in the medical record. If an individual 18 years of age or under would benefit from services provided as an individual or in a group setting utilizing "adult" services, this clinical decision should likewise be documented in the medical record.

Service limitations:

- 1 FTE to 8 individuals is the maximum group size for adults.
- 1 FTE to 4 individuals is the maximum group size for youth.

3. **Peer Support (PS)** services are individual-centered services with a rehabilitation and recovery focus. These services are designed to promote skills to cope with and manage psychiatric symptoms while facilitating the use of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the recipient's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the service recipient present. Services may be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

PS services may include the following components

- Help the individual to develop a network for information and support from others who have been through similar experiences
- Assist the individual with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses, or treatment with his or her clinician
- Assist the individual to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments

Provider qualifications

- Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Must have a high school diploma or equivalent
- Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a training approved by KDADS
- Must self-identify as a present or former recipient of mental health services.

Specialized Community-Based Rehabilitation Services – PS continued

Parent Peer Support will be covered utilizing current Peer Support Code H0038 (individual and group) and with the HQ modifier for group. Parent Peer Support providers must self-identify as a person with lived experience in raising a child with a Serious Emotional Disturbance (SED), SUD, or co-occurring mental health diagnosis.

There will be no age restrictions for parent receiving services, however the standard of 3 years age difference between the parent and provider applies. The current providers will be allowed to add this service to their array of services. The identified member's Medicaid ID number will be used for billing purposes. Group size is limited to a maximum of 8. This service cannot be billed if the identified member has an acute or residential level of care.

This service is covered, when based on clinical judgment, the member may not be present at the time the service is delivered, but the identified member remains the focus of the service. Parent Peer Support services involving the participation of a non-Medicaid eligible individual(s) must be documented in the medical record as having a direct benefit for the member. This documentation must demonstrate that the service is designed to address the identified member's individual needs on the treatment plan and outlining the expected interventions and improvements in behavioral health. This service connects the parent/guardian with an individual with lived experience to guide and support the parent/guardian in advocating for their member.

A licensed clinical practitioner will determine that parent peer support is necessary to be included in the patient's treatment plan. When the member is an adult, his/her permission must be obtained in writing.

To bill for PS, submit the following procedure codes and modifiers:

H0038	Individual	H0038HQ	Group

Service Limitations

- 1 FTE to 8 individuals is the maximum group size.

Effective with dates of service retroactive to July 1, 2023, Peer Support services (individual or group) may be billed by any behavioral health services provider who is an enrolled Kansas Medicaid provider. Each supervising licensed professional should bill for the services of Peer Specialists, Peer Mentors, and Parent Peer Specialists.

Supervising professionals should complete the required Peer Support Supervisor Training and maintain all training records for professionals and Peer Specialists, Peer Mentors, and Parent Peer Specialists.

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs Updated 04/25

Specialized Community-Based Rehabilitation Services – PS continued

Persons providing peer support services and the organizations that employ them must provide peer support services in a manner consistent with the requirements set forth by the KDADS including required training. See *Kansas Certified Peer Specialist Training.*

This service cannot be billed if the identified member has an acute or residential level of care either in person or via telehealth for individuals with a level of care included below and/or place of service 21. There will be no change in the established reimbursement rates.

Disallowed Level of Care Codes and/or with POS 21:

Member Level of Care (LOC) Code
100 – Behavior Management Mental Health
110 – Nursing Facility Head Injury
120 – Nursing Facility Swing Bed
130 – Nursing Facility Skilled Nursing
131 – Temporary Care Nursing Facility Skilled Nursing
140 – Nursing Facility Specialized Services/IDD
141 – Temporary Care Nursing Facility Specialized Services/IDD
160 – State Hospital Intellectual/Developmentally Disabled
170 – State Hospital Mental Health
171 – Temporary Care State Hospital Mental Health
230 – Nursing Facility Mental Health
231 – Temporary Care Nursing Facility Mental Health
990 – No State Payment Adult Care Home Resident

The following codes are utilized for billing Peer Support:

H0038	H0038 HQ

The following enrolled supervising Provider Type/Provider Specialties (PT/PS) will be allowed when billed as the performing provider:

Provider Type 09 – Advance Practice Nurse:

Specialty	Description
093	Nurse Practitioner (Other)
096	Psychiatric Nurse Practitioner

Provider Type 10 – Mid-Level Practitioner:

Specialty	Description
100	Physician Assistant

Specialized Community-Based Rehabilitation Services – PS continued

Provider Type 11 – Mental Health Provider:

Specialty	Description
108	Licensed Master's Level Psychologist (LMLP)
109	Licensed Clinical Psychotherapist (LCP)
112	Psychologist
115	Licensed Mental Health Professional (LMHP)
116	Licensed Clinical Mental Health Professional (LCMHP)
121	Certified Community Behavioral Health Clinic
123	Children with Severe Emotional Disturbances
125	Home Based Family Therapy
176	Alcohol and Drug Rehabilitation

Provider Type 31 – Physician:

Specialty	Description
316	Family Practitioner
318	General Practitioner
339	Psychiatrist
348	Addiction Medicine
349	Exempt License Physician

4. **Crisis Intervention (CI)** S9484U1 services are provided to an individual who is experiencing a psychiatric crisis. CI is a face-to-face intervention provided to an individual in crisis who requires the assistance of another person to regulate behavior and/or for stabilization.

   CI is designed to interrupt and/or ameliorate a crisis experience, including a preliminary assessment to determine risk and ability to engage, diagnostic assessment; immediate crisis resolution and de-escalation; and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

   CI goals are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI may occur in a variety of locations the individual lives, works, attends school, and/or socializes.

   CI is based on the individual's needs as assessed by a licensed mental health practitioner or physician and identified in the individual's chart.

   The QMHP or LMHP shall re-evaluate the need for crisis services for an individual every 72 hours or more frequently as needed.

   The following code is utilized when billing for CI:

S9484U1

Specialized Community-Based Rehabilitation Services – PS continued

Billing Guidelines - Time of Service:
Claims submitted for Crisis Intervention services shall meet the following requirements:

- Claims shall meet the midpoint time requirements of 51% or more (31 minutes) for 1 unit of service. No payment will be made for the CI services with less than 31 minutes.
- Post one (1) full unit of service (60 minutes), the units claimed may be decremented to the next midpoint time requirement when met (91 minutes), at which time the time requirement is met for 2 units and so on for subsequent units of service.
- For example:

Time of Service	Billable Quantity
0-30 minutes	0 units **(no payment will be made)**
31-60 minutes	1 unit *(as the first hour passed the midpoint)*
61-75 minutes	1.25 units
76-90 minutes	1.50 units
91-120 minutes	2 units *(as the second hour passed the midpoint)*
121-135 minutes	2.25 units
136-150 minutes	2.50 units
151-180 minutes	3 units *(as the third hour passed the midpoint)*

*Prior to the equivalent **of the time of service** equaling 1 unit- (31 minutes), do not claim or bill for .25, .50, or .75 units.

Note: Please review your claim to ensure the units of service entered on your claim are not the minutes of service delivery.

Billing Guidelines - Third Party Liability (TPL):
Other insurance carriers may reimburse the crisis intervention services (S9484 U1). The code will not be added to the TPL bypass list, providers should follow the guidance in the KMAP General TPL Payment Provider Manual, as Medicaid is the payor of last resort.

Eligibility criteria

- All individuals experiencing a serious psychological/emotional change that results in a marked increase in personal distress and exceeds the abilities and resources of those involved to effectively resolve it are eligible for CI services. The intent of CI services is to give the level of intervention necessary to help stabilize the individual, so a higher level of care is not necessary.
- An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning.
- Individuals in crisis who require this service may be using or abusing substances, such as illegal substances or prescription medications. Substance use or abuse should be recognized and addressed in an integrated fashion since it may be contributing to the personal distress that exceeds the abilities and resources of the individual.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS
Updated 02/25

Specialized Community-Based Rehabilitation Services – Crisis Intervention continued

Additional service criteria

- Services provided to children and youth must include coordination with family and significant others and, when feasible and appropriate, other systems of care such as education, juvenile justice, and child welfare. Coordination with other systems of care occurs mainly as a part of referral and follow-up after the crisis has been resolved. This coordination must be documented in the individual's chart.
- When the individual is unknown or new to the CMHC, the initial preliminary diagnostic and face-to-face assessment of risk, mental status, and medical stability must be completed by a QMHP or LMHP with experience regarding this specialized mental health service.
- The LMHP shall include the amount of time spent (start and stop) in the documentation if not captured in the Electronic Health Record (EHR).

Limitations/exclusions

- The appropriate MCO(s) shall be notified for any of their assigned individuals after 72 hours of crisis stabilization services have been provided and it has been determined additional crisis services are required to resolve the current crisis. CI services include residential stabilization services as well as placement in facilities offering short-term crisis stabilization beds. For services provided to individuals not assigned to an MCO, KDADS shall be notified as indicated.
  All CI Services require detailed documentation when it is provided more than 7 hours a day.
  Note: Re-evaluation for the need for crisis services is to be completed by a QMHP or LMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record and made available to the assigned MCO and KDADS upon request.
- If the current crisis is not anticipated to be resolved within 7 days, the MCO shall be notified and may require additional documentation to determine if additional services and continued services are justified. For services provided to individuals not assigned to an MCO, the KDADS Behavioral Health Crisis Program Manager shall be notified.
- For the safety of the individual and staff, applicable support services deemed medically necessary by the LMHP may be billed concurrently, not to exceed three hours (for a total of six hours), when the need is identified. The need for this level of support must be documented in the individual's chart and be re-evaluated by a QMHP or LMHP every 23 hours.
- The individual's chart must document the cause for termination of the crisis services to either a restored level of functioning or a higher level of care.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS
Updated 02/25

Specialized Community-Based Rehabilitation Services – CI continued

Components

- A preliminary diagnostic assessment of risk, mental status, and medical stability, along with the need for further evaluation or other mental health services. ***Note***: This shall include contact with the individual, family members or other collateral contacts (e.g., caregiver, school personnel) with pertinent information for the purpose of determining the best possible interventions including effective supports.
- Short-term crisis goal interventions including crisis resolution and de-briefing with the individual.
- Follow-up with the individual, and as necessary, with the individual's caregiver and/or family members.
- Consultation with a physician or with other providers to assist with the individuals' specific crisis.

Provider Qualifications

- Must be a QMHP or LMHP as defined by the state plan, with experience regarding this specialized mental health service and under the direction or supervision of a physician.
- Must have the appropriate certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks.
- Must complete a state-approved standardized basic training on the Kansas Train site - KDADS: Crisis Intervention (1065738) and a Nationally recognized CI Training, i.e.;(Mandt, TCI, CPI, MAB, SCM, and PIP) prior to delivery of service.

Documentation

- The chart shall document the individual's medical necessity for crisis intervention, crisis plan, treatment plan, re-evaluation for continued crisis intervention and coordination of services with the family and other systems of care (i.e., education, juvenile justice, substance use provider, child welfare, etc.).
- Re-evaluation to justify continued need for crisis services shall document the specific needs to be addressed during a continuation of services and the specific services to be provided.
- In instances of safety of the individual and staff, and concurrent billing; The need for this level of support must be documented in the individual’s chart and be re-evaluated by a QMHP or LMHP every 23 hours.

Quality Assurance

- For individuals assigned to an MCO, the assigned MCO shall be responsible for ensuring quality assurance for crisis intervention. This may include reviewing charts, requesting additional information, and monitoring services.

Specialized Community-Based Rehabilitation Services – CI continued

- The MCOs shall notify any provider of concerns related to crisis intervention and address any noncompliance issues as needed.
- KDADS Behavioral Health Crisis Program Manager shall be responsible for quality assurance for those receiving CI services who are not assigned to an MCO.

Definition

- Collateral Contact - A collateral contact is a source of information knowledgeable about an individual's situation. The collateral contact typically either corroborates or supports information provided by household members. Collateral contacts provide a third-party validation of the individual's circumstances and help ensure correct eligibility determinations are made.
- LMHP - is an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license.
- QMHP - a Master's level clinician who is licensed by the Kansas Behavioral Sciences Regulatory Board and employed by a CMHC, or an individual holding a medical degree (MD), or an advanced practice registered nurse (APRN).

5. **Mobile Response Stabilization Services/Mobile Crisis Response (MRSS/MCR) H2011 U1** services are available for person across the life span to access trained professionals who help deescalate behavioral health crises via a crisis helpline accessible to all individuals in Kansas. "Crisis" is to be self-determined by the caller. If a self-determined crisis by a caller cannot be resolved or deescalated during the call **or** the request is made for a face-to-face response, MRSS/MCR services~~.~~ dispatched to participating CMHCs/CCBHCs. MCO can also be deployed if the situation is likely to turn into a behavioral health crisis if supportive services are not provided.

   MRSS/MCR services are to be provided in person by teams of at least two individuals, at the preferred location of the individual or family (home, school, or other community-based setting). In circumstances where face to face service by a LMHP is not viable, the medical record should reflect the reason that a LMHP was unable to respond in person to the crisis. In those cases, utilization of telemedicine delivery by the LMHP is allowed, however, an in-person response should be made that would provide the telemedicine access to a LMHP.

   During the mobile response, the LMHP would be prepared to provide de-escalation, crisis intervention, safety planning, a referral to community-based services which may include crisis stabilization and if there is a need for an acute hospitalization, assessment, and or referral these services should be completed at this time. The LMHP would also be required to complete a State approved assessment tool, and a crisis plan with the individual and/or family if determined necessary, with documentation kept in the entity/organization's medical record.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS
Updated 10/24

Specialized Community-Based Rehabilitation Services – MRSS/MCR continued

MRSS/MCR is available 24 hours a day, 365 days a year.

MRSS/MCR services cannot be delivered when an individual has an inpatient status. The below listed Place of Service codes are excluded for MRSS/MCR services:

Place of Service Code
11 - Office
21 - Inpatient Hospital
22 - Outpatient Hospital
23 - Emergency Room
24 - Ambulatory Surgical Center
31 - Skilled Nursing Facility
32 - Nursing Facility
33 - Custodial Care Facility
51 - Inpatient Psychiatric Facility
52 - Psych Facility – Partial Hospitalization
53 - Community Mental Health Centers (CMHC)
54 - ICF for Individuals with Intellectual Disabilities (ICF/IID)
55 - Residential Substance Abuse Treatment Facility
56 - Psychiatric Residential Treatment Facility
57 - Non-residential Opioid Treatment Facility
58 - Non-residential Opioid Treatment Facility
61 - Comprehensive Inpatient Rehabilitation Facility
62 - Comprehensive Outpatient Rehab Facility
65 - End-Stage Renal Disease Treatment Facility

If the caller describes Life-threatening Risk, Emergency Services will be contacted if deemed unsafe or immediate active rescue is required.

Mobile Crisis Dispatch Levels:
Mobile crisis response teams are expected to arrive in-person at the location of the behavioral health crisis, or another location specified by the individual or family immediately within (1) one hour or two (2) hours in rural and frontier settings; not to exceed 3 hours from the time they are dispatched and, if involving children and youth (0-20) no later than 48 hours when the family or other referrer specifically requests a non-immediate response. Telehealth may be used to connect individuals in crisis to the or LMHP during the interim travel time.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS
Updated 10/24

Specialized Community-Based Rehabilitation Services – MRSS/MCR continued

Organizations providing MRSS/MCR for youth and children under 20, must have Provider Connect Access within 30 days of becoming a provider. These organizations, when receiving a referral from any crisis line, are dispatched to provide an in person mobile response:

- Organizations having Provider Connect Access, shall at the time of response call the state approved Department for Children and Families (DCF) helpline provider to initiate the authorization of the service.
  Or
- MRSS/MCR Team contacts the state approved DCF helpline provider by the next business day to report data, initiate claims payment and any additional and necessary follow-up. Completion of DCF and helpline providers mandated forms must be completed within the required time frame.

Claims will not be submitted to the MCOs for members in an unmet spenddown status. These costs are not member responsibility and should not apply to spenddown. The organizations will submit claims for non-Medicaid eligible individuals and those who are Medicaid eligible but not assigned to an MCO directly to the state approved DCF helpline provider for payment (including those members who are in an unmet spenddown status). For youth and children under 20, these costs reimbursed through the DCF funds.

Supportive Housing Services

The State of Kansas has opened the following HCPCS Level II Per Diem codes H0037 and H0037HK to enhance community supportive services. These per diem program codes were designed to assist high risk behavioral health consumers with intensive support services necessary to improve independent living skills and reduce symptoms that will interfere with a consumer's ability to sustain safe and stable permanent community housing. All support services and interventions must be medically necessary and driven by consumer choice. The intensive support service code is known as Operation Community Integration (OCI) programming and will be billed on a per diem basis. The level of care will be determined by the target population, consumers medical need, and the completion of the DLA 20 screen by a certified screener.

****Operation Community Integration (OCI) H0037**

Reimbursement will be provided for services targeting individuals at high risk of being unable to sustain independently in the community without intensive level supportive services offered through a CMHC and/or a State of Kansas Licensed SUD Provider.

- All residential and community OCI sites must be determined safe and habitable prior to being used as an OCI setting. Agencies participating in OCI must submit a completed OCI Habitability Check List on all consumers participating in OCI programming.
- All providers must be approved and in good contractual standing with KDADS, and the Managed Care Organizations contracted under the State Medicaid Authority of Kansas Department of Health and Environment, prior to any billing of the designated OCI codes.
- All provider agencies must submit an implementation and service delivery plan to KDADS Behavioral Health Commission for review and approval.

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs – Updated 10/24

Specialized Community-Based Rehabilitation Services (MRSS/MCR) continued

- Each CMHC provider will be given 24 months to have a base-line fidelity review for Evidence Based Practices, and it will be an expectation that all CMHC providers are using billing codes H0037 and H0037HK be within good fidelity standing.

****Intensive Community Residential Placement (ICRP) Support Services H0037HK**

The ICRP service level of need is targeted towards consumers whose screening indicates a need for medically necessary intensive on-site residential services, because of a history of unsuccessful integration in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric or incarceration. Payment for this level of service will be reimbursed through the Medicaid Billing Code H0037HK on a per diem rate and will involve admission to a congregate living environment with 5-16 beds.

The ICI Medicaid billing support code is targeted towards consumers who are unable to tolerate congregate living arrangements in which the presence of other consumers in their immediate living area tends to precipitate psychiatric and substance abuse relapse, aggression, or other behaviors associated with risk of re-hospitalization or incarceration. Payment for this level of service will be reimbursed through the Medicaid Billing Code H0037 at a per diem rate and will be administered in individual apartment settings (one person per apartment) in either a clustered location or the consumers current independent living/apartment setting (this will include emergency shelters and crisis diversion units) that are in the community.

Billing and Documentation Requirements

Codes H0037 and H0037HK are intended for direct face-to-face intensive services and supports delivered in both residential and community settings, will be subject to the prior authorization process, and the CMHC can bill Medicaid code H0037 for the completion of the admission screening process. These supportive services are intended to be intensive, directed supports that will be of a short-term nature and therefore, the initial prior authorization period will be for no more than 45 units for each level of service payment. If an individual should transition from a higher intensity of service billing the H0037HK to a lower intensity level of care service billing the H0037, the individual would have a total of 90 service units. These are to be considered soft limits and if criteria are met for a continuance, an extension can be considered and approved by the individual's MCO and KDADS BHS staff on a case-by-case basis. OCI services are billed at a daily per diem unit rate based on service delivery of a face-to-face intervention.

The following service codes and modifiers are allowed to be billed in addition to H0037 and H0037HK: 90832, 90834, 90837, 90847, 99211, 99212, 99213, 99214, and 99215.

Interventions and supports reimbursed through OCI Programs shall not be duplicated and shall NOT be part of the service menu offered through the OCI programs

8410. SERVICES NOTED WITH ** CAN ONLY BE BILLED BY CMHCs - Updated 10/24

****Intensive Community Residential Placement (ICRP) Support Services H0037HK continued**

On each day that an OCI code is billed the client chart must reflect documentation of intensive services and supports delivered that day. Examples of appropriate documentation may include, but is not limited to the following: daily summary progress notes, weekly summary progress notes, shift notes, progress notes documenting individual interventions with consumers including but not limited to individual assistance (i.e. Crisis assistance/support, conflict management, behavior re-direction, prompting and reminders, providing education on goal directed activities, assistance with completions of HUD documentation for access to HUD housing and programming supports, vocational rehabilitation referrals, and/or food stamp applications, communication with SOAR Eligibility Specialist for SSA up-dates and Medicaid application and reviews.

Required Documentation

Consumer charts must include and/or demonstrate the following approved services and supports;

- Copy of the initial screen, eligibility and recommendations made by the (Certified DLA 20 admissions screener)
- Treatment plans must be completed within 72 hours of admission to the program
- Treatment plans must be modified and updated as necessary and reviewed with treatment team monthly. Proof of treatment plan review shall be placed in consumer's chart
- Admission Note that supports which target population and level of service need the admitting consumer qualified under
- Face-to-face interventions
- Discharge documentation should include the outcome of the local HUD COC Coordinated Entry assessment, and the name/location of the Coordinated Entry Access Point that the consumer participated in, and a copy of the Homeless Certification Worksheet.
- Individuals in Residential Programming ICRP level of care must also have entries in a safety log as well as progress notes that reflect safety monitoring, and evidence of periodic safety checks overnight
- Individuals in the ICI level of care must have a critical intervention plan for all consumers participating in this level of care in the consumer's individual file

Providers must follow applicable KDADS to provide these services. Policies can be found on the KDADS website. Tools and forms can be downloaded on https://www.kdads.ks.gov/provider-home/providers/policies-and-regulations. Information for OCI specific to licensed Substance Use Disorder providers reference the KMAP *Substance Use Disorder Fee-for-Service Provider Manual*.

8420. DEFINITIVE CRITERIA Added 05/25

Providers must keep and maintain, in accordance with K.A.R. 30-5-59, medical records for Medicaid service recipients to consist of, at least, the following:

- Individual's identification number.
- Date of admission to treatment service.
- Treatment plan that has been completed within 14 days of admission to treatment services, not necessarily intake, which includes recommendations for treatment and has been reviewed and updated within the last 180 days.
  Note: This treatment plan must meet the following objectives:
  - Treatment regimen to achieve those objectives
  - Projected schedule for service delivery
  - Type of personnel required to deliver the services
  - Projected schedule for review of the individual's condition and updating of the treatment plan
- Current diagnosis that has been reviewed and updated within the last 180 days.
  Note: This update must also describe the individual's progress.
- Prognosis that has been reviewed and updated within the last 180 days.
  Note: The 180-day review is not required if the services are provided solely by a medical professional such as a physician or registered nurse for medical conditions such as medication check or other medical treatment and are documented by clinical notes.

  Note: For outpatient treatment, a chronological record includes all treatment provided to the individual, all activities performed on the individual's behalf, the type or mode of treatment, and the amount of time per session of treatment. These entries must include the signature and credentials of the person responsible for the entry and the date the service was rendered. The record must reflect the relationship of the services to the treatment plan.

  Note: If services not shown in the treatment plan or services differing from the treatment plan in scheduling frequency, duration, or designated staff are delivered to the individual, a detailed explanation of how these services relate to the treatment plan must be included in the record

  Note: The waiver of not more than 90-day periodic treatment plan update to not more than 180-day period treatment plan update applies to the following:
  - This waiver applies to licensed community mental health centers and licensed community mental health clinics as defined by K.S.A.39-2002(b).
  - This waiver does not apply to any other category of licensure outlined in K.S.A.39-2002 including: crisis intervention center, hospital, private psychiatric hospital, psychiatric residential treatment facility, resident care facility or service provider. "Services" means the following types of behavioral health, intellectual disability, developmental disability and other disability services, including, but not limited to: residential supports, day supports, care coordination, case management, and shared living.
  - This waiver also does not apply to Substance Use Disorder programs outlined in K.S.A.65-4001.

8425. AUTISM DIAGNOSIS AND DIAGNOSTICIANS CLINICAL REQUIREMENT Updated 08/26

Autism Diagnosis and Diagnosticians Clinical Requirement for individuals aged 20 and younger with autism spectrum disorder (ASD) must receive a diagnosis from a Kansas Behavioral Sciences Regulatory Board (BSRB) clinical psychologist or qualified physician. A multidisciplinary diagnostic approach is preferred.

Allowed provider types include the following:

11/112 (Psychologist)
31/316 (Family Practitioner)
31/318 (General Practitioner)
31/326 (Neurologist)
31/339 (Psychiatrist)
31/345 (General Pediatrician)
31/349 (Exempt License Physician)
31/351 (Indian Health Services)

Qualified Kansas BSRB clinical psychologists must meet the standards outlined in K.S.A. 74-5310(3) and (4):

- Hold a doctor's degree based on a program of study primarily in psychology from an educational institution with graduate program standards consistent with Kansas state universities, or a substantially equivalent program in subject matter and training; and
- Have at least two (2) years of supervised experience, including significant experience providing psychological services that meet the Behavioral Sciences Regulatory Board's approved standards for the applicable psychological service.

Qualified physicians include developmental/behavioral pediatricians, psychiatrists, neurologists, primary care physicians, and other physicians listed above who have documented additional training in ASD diagnosis.

- Documentation of additional ASD diagnostic training may be subject to periodic MCO audit or inquiry.

The ASD diagnostic evaluation must include these required elements:

1. Diagnostic criteria and symptom severity level based on the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. Use of a validated ASD diagnostic assessment tool, such as the Autism Diagnostic Observation Schedule (ADOS) or the Childhood Autism Rating Scale (CARS).

The ASD diagnostic evaluation should also include these recommended components:

1. A cognitive evaluation using a validated tool, such as the Clinical Adaptive Test/Clinical Linguistic and Auditory Milestone Scale (CAT/CLAMS), Mullen Scales of Early Learning (MSEL), or Bayley Scales of Infant Development (BSID). A cognitive evaluation completed by a school district using a validated tool may also be included.
2. An adaptive behavior measure, such as the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS), may also support the diagnostic process.

ASD screening tools such as the Modified Checklist for Autism in Toddlers (MCHAT), Autism Behavior Checklist (ABC), Autism Spectrum Screening Questionnaire (ASSQ), Rapid Interactive Screening Test for Autism in Toddlers (RITA-T), and Screening Tool for Autism in Toddlers and Young Children (STAT) have clinical value in recognizing children at risk of having ASD, but the diagnosis of ASD must rest on validated diagnostic tools such as those listed above (ADOS and CARS).

8425. AUTISM DIAGNOSIS AND DIAGNOSTICIANS CLINICAL REQUIREMENT continued
Updated 08/26

Autism Screening and Treatment
Effective with noted date above, once an individual is diagnosed with autism spectrum disorder by a qualified diagnostician as per this policy, they are eligible for autism treatment, including applied behavioral analysis (ABA) therapy, without the need for a re-evaluation of their autism spectrum disorder diagnosis. There is also no time limit on how soon they begin autism treatment, including ABA therapy, following their diagnosis of autism spectrum disorder.

Transition Provisions for Current Members
For individuals already approved and receiving autism treatment, including applied behavioral analysis (ABA) therapy, who have been diagnosed with autism spectrum disorder by a provider who does not meet the updated diagnostician and/or diagnostic requirements as per this policy, will have two (2) years to obtain an updated autism spectrum disorder diagnosis by a qualified provider. The updated diagnosis does not necessarily need to involve a complete diagnostic evaluation as long as the diagnostic criteria in this policy are met and a qualified diagnostician is confirming the diagnosis. A validated ASD diagnostic tool, used either during the original diagnostic process or during the diagnostic re-evaluation by a qualified provider, remains an essential element of the ASD diagnosis.

8430. TELEMEDICINE ALLOWANCES FOR OUT-OF-STATE (OOS) PHYSICIANS Added 07/25

Effective with dates of service on or after July 1, 2025, out-of-state physicians may provide telemedicine services to patients located in Kansas if they have obtained a telemedicine waiver from the Kansas Board of Healing Arts (KSBHA), in accordance with K.S.A. 65-28,135. This provision applies only to physicians who do not hold a current Kansas license.

Key Requirements:

- Out-of-state providers must be enrolled with KMAP to submit claims for telemedicine services. ***Note*:** The telemedicine waiver must be obtained from KSBHA.
- The new OOS specialties are:
    - **355 – OOS Addiction Medicine** (Taxonomy: 207QA0401X)
    - **356 – OOS Psychiatrist** (Taxonomy: 2084P0800X)
- This policy does not apply to physicians already licensed in Kansas.
- Hospital admitting privileges are not required for out-of-state providers delivering telemedicine services only.

All other existing policies related to telemedicine services remain in effect. Refer to ***General Benefits Manual*** **Section 2720 – Telemedicine** for comprehensive guidance.

APPENDIX

CODES Updated 10/24

The following codes represent a list of mental health services billable to KMAP for individuals **not assigned** to an MCO.

Use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the participant ID number or benefit plan. Information is available:

- On the public website
- On the secure website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance 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.

Note: Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for complete details regarding Telemedicine.

ADMISSION EVALUATION (DIAGNOSTIC)

90791	90792							

EVALUATION AND MANAGEMENT

99211	99212	99213	99214	99215	99221	99222	99223	99231
99232	99233	99238	99239	99366	99368			

KMAP does not recognize the following AMA CPT consultation codes for payment:

99242	99243	99244	99245	99252	99253	99254	99255		

MEDICATIONS

J0515	J2680*	J1631*	J2794*	J3490*				

***PA required.**

Note: When billing J-codes, the National Drug Codes (NDCs) making up the HCPCS code being billed must be submitted on the claim detail.

PSYCHOLOGICAL TESTING

96130	96131	96136 U8	96137 U8	96138 U8	96139 U8	96146		

SPECIALIZED COMMUNITY-BASED REHABILITATION SERVICES

H0036HA	H0036HB	H2017	H2017TJ	H2017HQ	H0038	H0038HQ	H2011U1	S9484U1

THERAPY – FAMILY

90832	90834	90837	90839	90840	90847	90847HK		

CODES Updated 10/24

THERAPY – GROUP

90853								

THERAPY – INDIVIDUAL

90832	90834	90837	90839	90840				