Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Provider Manual

Substance Use Disorder

Updated 05.2024

PART II
SUBSTANCE USE DISORDER PROVIDER MANUAL

Introduction

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

DISCLAIMER: All related materials for the traditional Medicaid fee-for-service program are available on the Kansas Medical Assistance Program (KMAP) website. For provider resources available through the KanCare Managed Care Organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

PART II
SUBSTANCE USE DISORDER PROVIDER MANUAL

Created 12/17

This is the provider specific section of the provider manual. This section (Part II) was designed to provide information and instructions specific to providers of Substance Use Disorder (SUD) services. 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 SUD providers must use when the member 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 SUD services that are reimbursed by the KMAP.

The **Appendix** subsection contains information concerning codes.

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.

Compliance with 42 U.S.C. 290dd-2(g)
Similarly, providers are required to comply with restrictions placed upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any substance use disorder program. Reference the **Substance Abuse Confidentiality Regulations** section of the Substance Abuse and Mental Health Services Administration SAMHSA website for the definition of a federally assisted program and additional guidance.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to the Kansas Medical Assistance Program (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. -3853 and amendments thereto.

7000. Created 12/17

Introduction to the CMS 1500 Claim Form and UB-04

SUD 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, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

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.

Any of the following billing errors may cause a paper CMS 1500 Claim Form to deny or be sent back to the provider:

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

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*.

Submission of Claim

Send completed claim and any necessary attachments to:

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

BILLING INSTRUCTIONS

7000. Updated 03/22

Unit Billing

The appendix provides procedure code and time definitions for billing specific procedures (for example, 30 minutes, 1 hour). 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.

Medication Assisted Treatment – Opioid Treatment Programs

Effective October 1, 2020, through September 30, 2025, all Medication Assisted Treatment (MAT) drugs and biological products used for Opioid Use Disorder (OUD) will be covered. All MAT drugs and biologicals billed through the medical benefit require a diagnosis code to be considered for payment.

Medications Covered

MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines. The following drugs are covered MAT 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 (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 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

Medication Assisted Treatment – Opioid Treatment Programs continued

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 SUD program as allowed by State Licensing regulations and/or standards.

Coding for MAT 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:

- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)
- 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 MAT 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)
- Take-home supplies of methadone (G2078) and take-home supplies of oral buprenorphine (G2079)
- Additional counseling furnished (G2080)

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.

7000. **Updated 03/22**

Medication Assisted Treatment – Opioid Treatment Programs continued

- G2070 and G2072 may not be billed more than once every 6 months.
- G2076 (describing intake activities) 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 (one month take home supply). 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 (take-home supply of methadone) may only be billed with G2067 (methadone weekly episode of care).
- G2079 (take-home supply of buprenorphine) may only be billed with G2068 (buprenorphine weekly episode of care).
- 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.
- 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.
- 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.

Medication Assisted 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 MAT.
- 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.

Medication Assisted Treatment - Office Based Opioid Treatment (OBOT) Programs

MAT drugs, excluding Methadone, will be covered for Office-based Opioid Treatment (OBOT), according to the inclusions and exceptions listed below. Methadone used for MAT is only covered in an OTP setting. MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines. 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.

7000. **Updated 03/23**

Medication Assisted Treatment – Opioid Treatment Programs continued

Buprenorphine products indicated for MAT 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 (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 MAT.

Kansas Medicaid will no longer require the DATA Waiver (X-Waiver) to be obtained and submitted for verification, by the provider, before prescribing medications for the treatment of Opioid Use Disorder (OUD).

Physicians, nurse practitioners, physician assistants, and qualified mid-level practitioners approved by Substance Abuse and Mental Health Services Administration (SAMHSA), 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). More information can be found here.

From October 1, 2018, and ending on October 1, 2023, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives are included in the provider types approved for MAT 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.

Services covered

The SUPPORT Act requires counseling and behavioral therapy to be part of a MAT 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:

7000. **Updated 03/22**

Medication Assisted Treatment – Opioid Treatment Programs continued

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

*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 MAT 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.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Created 12/17

SUD services are exempt from copayment requirements.

8200. MEDICAL ASSESSMENT Created 12/17

The purpose of SUD assessment and referral is to determine the individual's SUD treatment needs. If indicated, this may include the appropriate clinical placement for treatment or other referrals using the State Approved Assessment Tool. The assessment and subsequent documentation must include factors pertaining to the individual's emotional and physical health, social/family background, legal history, employment history, substance use/abuse, and prior treatments regarding any of the reported conditions. The State Approved Assessment Tool may be administered only by approved center staff who have completed training on this placement/assessment instrument as evidenced by training certificates.

Approved center staff is defined as clinical program staff members rendering Medicaid-reimbursable services who are credentialed according to the State of Kansas Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs.
To provide Medicaid-funded rehabilitation SUD treatment services, those services must be recommended by either a physician or other licensed practitioner of the healing arts as medically necessary to restore an individual to his or her best possible functional level.

8300. BENEFIT PLAN Created 12/17

KMAP service recipients 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. For example, SUD services are **not** covered for MediKan participants under KMAP.

- If the individual is assigned to an MCO, contact the specific health plan for managed care assistance.
- If the individual resides in a psychiatric residential treatment facility (PRTF), all SUD services are the responsibility of the PRTF.

BENEFITS AND LIMITATIONS

8400. Created 12/17

PROVIDER REQUIREMENTS

Enrolled SUD treatment providers must be licensed by the Kansas Department for Aging and Disability Services (KDADS). KDADS standards require these providers to be trained in the use of the State Approved Assessment Tool and to have the State Approved Assessment Tool software installed as part of their operations systems to meet Medicaid eligibility requirements and to receive a license from KDADS.

- Potential providers must complete the following steps, which will be verified in writing by KDADS prior to the enrollment application with the fiscal agent:
    - Complete a computer questionnaire and security forms provided by KDADS to ensure there is sufficient hardware, software, and Internet access to meet the electronic data collection and reporting requirements
    - Receive authorization from KDADS to download and install the State Approved Assessment Tool system
    - Provide evidence that the clinical staff have attended a KDADS-approved State Approved Assessment Tool training
    - Provide proof of a current license issued by KDADS as acceptable verification that the provider meets all State Approved Assessment Tool training and State Approved Assessment Tool installation requirements necessary for KMAP enrollment and revalidation
- After completion of the previous steps, KDADS will issue a letter of approval and the potential provider will complete an enrollment application with the fiscal agent.
- Upon completion of the enrollment application with the fiscal agent, the potential provider will contact KDADS to ensure the process for electronic data collection has occurred.

All Services

- Only the services described herein and provided by approved center staff in the manner described and in accordance with the service recipient's individualized treatment plan are reimbursable SUD services.
- These services must be determined to be medically necessary by the MCO for individuals served by an MCO or by the contracted administrative services organization (ASO) for all others.

General Charting Documentation Guidelines

- All clinical activity delivered in the course of treatment must be outlined in the individualized treatment plan with specific goals based on the assessment of medical necessity for treatment. This treatment plan is reviewed and updated regularly according to guidelines based on the individual's assigned level of care.
- Documentation must show progress, be legible, and include, at a minimum, the following:
    - Start and stop times
    - Type of clinical activity
    - Major issues covered from the treatment plan goals
    - Complete date to include day, month, and year
    - Staff providing the service with staff signature including credentials
    - Progress notes related to the treatment plan goals

8400. Created 12/17

Acute Detoxification Treatment

- Acute Detoxification Treatment provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services.
- In this modality of treatment, 24-hour observation, monitoring, and counseling services are available.

Intensive Outpatient Treatment

- Intensive Outpatient Treatment involves treatment activities based on the individualized treatment plan where services are offered in regularly scheduled sessions throughout the week by provider staff. Individuals participate in structured therapeutic activities that may include SUD educational didactic groups, group counseling, and individual counseling.
- These services must be based on an individualized treatment plan including assessment, counseling, and activity therapies or education.
- It is only acceptable to bill for this treatment daily if either of the following apply:
    - The individual participates in a minimum of 9 hours of service in a 7-day period.
    - For an individual who is 17 years of age or younger, a minimum of 6 hours of counseling services are provided in a 7-day period.

Inpatient Treatment

- Inpatient Treatment is delivered in both acute care and longer-term inpatient settings. This modality of care is appropriate for those individuals whose biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care.
- This program encompasses a planned regimen of 24-hour medically directed evaluation and treatment services. Although treatment is specific to SUD issues, the skills of the interdisciplinary team and the availability of support services allow co-occurring biomedical conditions and mental disorders to be addressed.

Outpatient Counseling

- Outpatient counseling (behavioral health counseling and therapy or group counseling by a clinician) provides nonresidential SUD treatment in an individual or group setting or both. Group outpatient counseling consists of counseling delivered in a group setting to two or more individuals.
- Treatment must be based on an individualized treatment plan which is based on the assessment. This initial treatment plan must be completed within 30 days of the individual's admittance into treatment and must be updated every 90 days. The provider must meet documentation requirements for every session.
- These outpatient services are limited to 9 hours of counseling services each 7-day period.

Peer Support Services

- 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 substance abuse symptoms while facilitating the use of natural resources and the enhancement of community living skills.

8400. Created 12/17

Peer Support Services (continued)

- Activities included must be intended to achieve the identified goals or objectives as set forth in the service 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 individual present.
    - Services may be provided individually or in a group setting.
    - Most PS contacts must occur in outpatient treatment centers and/or community locations where the individual lives, works, attends school, and socializes.
- Providers must follow applicable KDADS Behavioral Health Services Commission Peer Support Services policies to provide these services. Policies can be found on the KDADS website.
- PS services will help the individual to develop a network for information and support from others who have been through similar experiences.

Person-Centered Case Management

- Person-Centered Case Management is defined as a one-on-one goal-directed service for individuals with an SUD through which the individual is assisted in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services.
- For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO or by the contracted ASO for all others.
- The case manager providing the service must complete the certification requirements to become a Person-Centered Case Manager. Certification requirements can be found on the KDADS website.

Screening, Brief Intervention, and Referral for Treatment (SBIRT)

- Screening, Brief Intervention, and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents, and injuries. SBIRT is designed to identify an individual who has an alcohol and/or other substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use.
- Practitioners providing SBIRT services to Medicaid-eligible patients in Kansas must:
    - Meet the KDADS requirements including being currently licensed in good standing as an approved professional type
    - Complete and pass an approved SBIRT training

Individual practitioners

- Shall submit documentation of training completion and current professional licensure at the time of enrollment, recredentialing, or revalidation to the following:
    - Prior to July 1, 2018, the applicable KanCare MCO or KMAP for fee-for-service based on the type of patients that the provider intends to serve.
    - KMAP for both managed care and KMAP fee-for-service patients.

8400. Created 12/17

Facilities

- Facilities shall maintain documentation of training completion and professional licensure for each practitioner performing SBIRT services in the facility. The policy requires the facility to attest at enrollment, recredentialing, or revalidation that the facility will only bill for SBIRT services if the employee performing the service has met the training and certification requirements.
- Services to patients must be provided in an approved service location.
- The SBIRT practitioner will conduct a brief screen using an approved brief screening tool appropriate for the patient's age and reason for screening.
- A positive brief screen results in a full screen using one of the approved, evidence-based screening tools appropriate for the patient's age and reason for screening. Reimbursement for full screens is limited to one per person per year.
- A positive full screen will result in either:
    - A brief intervention for individuals with an alcohol and/or substance use disorder or who are at risk of developing one.
    - A referral to a SUD treatment program for individuals with severe alcohol and/or other substance abuse and dependence.
- An intervention:
    - Involves a brief one-on-one session in which concerns about an individual's alcohol and/or other substance use are expressed and advice to cut down or moderate an individual's behavior is given.
    - Includes feedback on alcohol and/or other substance use patterns.
    - Focuses on increasing motivation for behavioral change to reduce harmful levels of alcohol/and or other substances.
    - Includes strategies such as education, simple advice, brief counseling, continued monitoring, or referral to a substance use disorder treatment specialist.
- More information on SBIRT can be found on the SBIRT page of the SAMHSA website or the Policies and Regulations page of the KDADS website.

SUPPORTIVE HOUSING SERVICES

The State of Kansas has opened the following HCPCS Level II per diem codes to enhance community supportive services H2016 and H2016HK. These per diem 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 following: the target population, the consumer's medical need, and the completion of the Daily Living Activities (DLA) 20 screen by a certified screener.

8400. Updated 01/20

OPERATION COMMUNITY INTEGRATION

Reimbursement will be provided for services that target individuals at high risk of being unable to sustain independent living in the community without intensive level support services offered through a Community Mental Health Center (CMHC) and/or a ***State of Kansas Licensed Substance Use Disorder (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 (MCO) 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.
- Each SUD provider will be given 24 months to have a baseline fidelity review for Evidence Based Practices. It will be an expectation that all SUD providers using billing codes H2016 and H2016HK be in good fidelity standing.

The Intensive Community Residential Placement (ICRP) Support Services (H2016HK):

The ICRP service level of need is targeted toward 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 with the use of Medicaid Billing Code H2016HK on a per diem rate and will involve admission to a congregate living environment with 5-16 beds.

Intensive Community Integration (ICI) Support Services:

The ICI Medicaid billing support code is targeted toward 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 Medicaid Billing Code H2016 at a per diem rate and will be administered in individual apartment settings (one person per apartment) in either a clustered location or the consumer's current independent living/apartment setting (this will include emergency shelters and crisis diversion units) that are in the community.

BILLING AND DOCUMENTATION REQUIREMENTS:

- Codes H2016 and H2016HK are intended for direct face-to-face intensive services and supports delivered in residential and community settings. Use of codes will be subject to the prior authorization process, and the SUD provider can bill Medicaid code H2016 for the completion of the admission screening process.
- Support services are intended to be intensive and directed support that will be of a short-term nature. Therefore, the initial prior authorization period will be for no more than 45 units for each level of service payment. If an individual transitions from a higher intensity of service (billed with H2016HK) to a lower intensity level of care service (billed with H2016), 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

8400. Updated 01/20

BILLING AND DOCUMENTATION REQUIREMENTS (continued):

individual's MCO and KDADS Behavioral Health Services (BHS) staff on a case-by-case basis. Operation Community Integration (OCI) services are billed at a daily per diem unit rate based on service delivery of a face-to-face intervention.

- Criteria for billing these codes is dependent upon the SUD provider adhering to the Evidence Based Programing Practices (EBP) of Housing First (or an alternative EBP program selected and approved by the Behavioral Health (BH) Commissioner of KDADS), IPS supported employment, and the promising practices of SOAR as they relate to the individual being served.

The following service codes can be billed in addition to H2016 and H2016 HK:
H0001; H0004; H0005; H0015.

Each day that an OCI code is billed, the client chart must reflect documentation of intensive services and supports delivered that day. 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 redirection, prompting and reminders, providing education on goal-directed activities, assistance with completion 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 the 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 Continuum of Care (COC) Coordinated Entry Assessment, the name/location of the Coordinated Entry Access Point that the consumer participated in, and a copy of the Homeless Certification Worksheet.
- Individuals in the Residential Programming Intensive Community Residential Placement (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 file.

Providers must follow applicable KDADS policies to provide these services. Policies can be found on the KDADS website. Tools and forms can be downloaded here: https://www.kdads.ks.gov/provider-home/providers/policies-and-regulations.

8400. Updated 08/20

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

APPENDIX

CODES

Created 12/17

The following *Current Procedural Technology (CPT)* codes represent a list of SUD services billable for individuals receiving services.

ASSESSMENT AND REFERRAL (State Approved Assessment Tool)

H0001	1 unit = 1 assessment

SBIRT ALCOHOL AND/OR DRUG SCREENING

H0049	1 unit = 1 full screen

SBIRT ALCOHOL AND/OR DRUG BRIEF INTERVENTION

H0050	1 unit = 15 minutes

SBIRT ALCOHOL AND/OR DRUG SCREENING AND BRIEF INTERVENTION

99408	1 unit = 15-30 minutes
99409	1 unit = More than 30 minutes

INPATIENT TREATMENT

H0019	1 unit = 1 day

INTENSIVE OUTPATIENT ADULT/YOUTH

H0015 U5	1 unit = 1 day

INTERMEDIATE TREATMENT

H0018	1 unit = 1 day

OUTPATIENT INDIVIDUAL

H0004	1 unit = 15 minutes

OUTPATIENT GROUP

H0005 U5	1 unit = 15 minutes

PEER SUPPORT INDIVIDUAL

H0038	1 unit = 15 minutes

PEER SUPPORT GROUP

H0038 HQ	1 unit = 15 minutes

Updated 05/24

PERSON-CENTERED CASE MANAGEMENT

H0006 U5	1 unit = 1 hour

~~**TELEMEDICINE ORIGINATING SITE FACILITY FEE**~~

~~**Q3014**~~	~~1 unit~~

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