

Kansas Health Solutions
Frequently Asked Questions (FAQs)
October 22, 2007

1. What is a grievance/appeal/state fair hearing?

A grievance is an expression of dissatisfaction about service issues, other than an action. A grievance shall not include alleged abuse, neglect, serious injury or death if a recipient when there is an apparent or suspected rights violation page 46 in the printed Member Handbook. A grievance, appeal, and state fair hearing are the steps that a Member may take to address problems. Grievances, appeals and state fair hearings and inquiries regarding the process can be directed to a KHS Ombudsman by calling 866-547-0222.

An appeal is a request for a review of an action. An action is a decision that negatively impacts a Member's ability to receive a service, or the amount of service wanted and when a Member wants it. It may also mean that KHS or its Provider Network did not make a decision about what services a member received, or did not provide the Member with authorized services within certain time frames.

A State Fair Hearing is a State level review of member disagreements with Kansas Health Solutions' denial, reduction, suspension or termination of Medicaid services. State administrative law judges perform the reviews. The judges do not work for Kansas Health Solutions.

2. How do Members find/change an eligible provider in my area?

When Members receive the Member Handbook, they should also receive a provider directory. This directory is also available at www.kansashealthsolutions.org. Members may change providers at any time. For assistance, KHS Members should call Member Services at 888-547-2878. A primary care physician reference is not needed in order to select or change mental health providers.

3. Are the access standards times different under the new contract starting 7/1/07 with KHS?

Yes. The access standards are listed on pages 51-53 of the Provider Manual. These are the standards providers are held to. If any provider is having difficulty adhering to the standards, please call KHS at 785-575-9393 or 866-547-6457.

4. Is a homeless shelter considered homeless, and who is responsible for confirming Member's address upon discharge from state and local hospitals?

When discharge of someone from any hospital is determined appropriate by hospital staff, effective and efficient services and related supports are promptly developed, finalized, and accessed so that discharge can occur. Once a discharge date is set by hospital staff, the person should be discharged by that date, and should be discharged to appropriate aftercare services and supports and not be discharged to homelessness (including all homeless shelters).

5. Clarify the difference between Attendant Care for the 1915(b) population and the HCBS Waiver population.

The only difference between 1915 (b) Attendant care and HCBS SED Waiver Attendant Care is the funding stream. Both require pre-authorization. For the 1915(b) Attendant Care there is a limited pool of funds so services will be authorized within the available funding. The HCBS SED Waiver attendant care is only available when a member is an SED waiver beneficiary. A SED Waiver beneficiary cannot receive 1915 (b) attendant care.

6. Who is responsible for PRTF admissions?

The certification of need is required for entrance into a PRTF and includes both the CBST Process and the PRTF screen. LMHP trained screeners conduct the PRTF screen. PRTF employees may not screen into their own facility. The CBST Process must be completed by the Community Mental Health Center. Prior to conducting the PRTF screen, authorization must be obtained by contacting Provider Relations at 866-547-6457.

7. How do Members find a provider who speaks their language?

KHS provides a language line free of charge. This line should be used for interpretation services, rather than relying on friends/family members. The number for this line can be found on the KHS website. Member Services will assist with finding a Provider who speaks the Member's language. The Member can call directly to obtain language line information by contacting 888-547-2878.

8. Where can a copy of the Provider Agreement and Fee Schedule be found?

Providers may call Provider Network at 866-547-0222 and request that a Provider Agreement and Fee Schedule be sent to you.

9. Do Providers need both KMAP and NPI#?

Yes. To be a Member of the KHS Network, both ID numbers are required.

10. How will Providers be reimbursed if a Member receives 2 mental health services in the same day but with separate providers and how can crisis be billed by concurrent Providers?

If a service is covered then each provider bills under their own NPI and KMAP #. Services then are paid according to the fee schedule.

If covered services are appropriate to be provided on the same day by different rendering providers, these services may be billed under each rendering providers NPI and KMAP # at the fee schedule rate. CPST, crisis intervention and attendant care services provided in multiple units on the same day may be billed with the 59 modifier.

Crisis services may be billed concurrently with a screen if performed by different rendering providers.

Information related to this FAQ was included in the 1.1 Provider Notice dated September 1, 2007 as well as in the August KHS Dispatch (Newsletter).

11. How do we determine the status of a claim and any under or overpayment of a bill?

Providers can check status thru Provider Connect and can call the Providers/Claims hotline at 866-547-6457.

12. How do services get authorized?

After a contracted provider assesses the patient and determines services desired, the patient is registered through Provider Connect. KHS staff may approve, deny, suspend, or reduce services as determined appropriate utilizing medical necessity criteria and other factors. If you have further questions, please call 866-547-6457.

13. Can providers begin providing services prior to the KHS credentialing process being completed? If no, how long do we anticipate the process to take?

During the transition period from July 1, 2007 to September 1, 2007, a provider can be noted as network eligible when they have signed a contract with KHS but have not yet fully completed the credentialing process. However, beginning September 1, 2007, all providers must be fully credentialed by KHS prior to providing services to KHS members. When fully credentialed, providers will receive notice from KHS.

14. Is there issue or concern if clients see me for meds and/or meds with minimal therapy and I refer to a Community Mental Health Center for additional services/evaluations?

No, it is the hope that Providers will refer clients to a CMHC for additional services beyond the attending provider's scope.

15. For 24/7 care, is it acceptable to provide CMHC crisis line on a voice message if I am unable to answer the phone for any reason?

It is acceptable for a Provider to list the crisis line for the CMHC providing there is a written contract between the Provider and the CMHC for this coverage by the CMHC. The same is true for private Provider to private Provider.

16. Can Providers "share" clients (can a Member get school based CPST in 1 county and home based CPST in the other county)?

Yes. Members have a choice to receive services from any KHS credentialed Provider in Kansas. Providers can coordinate care.

17. If a Member disagrees with the diagnosis, can they seek a second opinion and is the provider reimbursed for the second opinion?

Yes, KHS members may request a second opinion. The KHS network of providers can provide a second opinion and will approve a member receiving a second opinion from outside the KHS Provider network. Upon request Members will be provided two additional names of eligible providers in your area. To obtain information regarding a 2nd opinion call Provider Services at 866-547-6457.

18. If a Medicaid Member does not follow through with services can a Provider deny services?

If a Provider has concerns about a member not following thru with services please contact the KHS Clinical Director at 866-547-0222.

19. The manual indicates 6 hours of testing are available per calendar year. Does this apply to adults and kids?

The standard applies to all KHS members. If there is a need to do more testing, the case should be discussed with the KHS Chief Medical Officer. You may call Provider Relations @ 866-547-6457 to request additional hours; Provider Relations will then contact the Chief Medical Officer to discuss.

20. Are there Case Conference hours (4 hrs/yr for Members) to bill available for QMHPs participating in care coordination conferences?

Case Conference billing will be limited to participation of one LMHP from each care delivery organization present. Case Conferences are not to exceed 90 minutes per conference.

21. How many hours of Home Based Family Therapy can be provided to a Member?

Home-based family THERAPY (not treatment) is part of the regular outpatient therapy service array available to KHS members. As described within the KHS Provider Manual, family therapy is authorized for up to 40 hours per calendar year. After such time is exhausted, additional service may be prior authorized so long as medical necessity can still be documented. Additionally, when HBFT is provided, the child must be present during the therapy session.

22. Can a TCM case manager provide billable crisis intervention or CPST to a consumer if filling in for another case manager or if they are responding to a crisis? (e.g. To cover for a staff member who is absent)

A TCM Case Manager may not provide other direct services to the member that they are providing TCM to.

23. Why pre-auth for case conference?

Case Conference is a 1915 (b) service, not a state plan service. For this reason, there is a limited pool of funds available and prior authorization is required to manage within those available funds.

24. Define and describe PRTFs and screenings.

INPATIENT SCREEN URGENCIES
EFFECTIVE OCTOBER 1, 2007

Urgency standards for inpatient screens can be found on pages 29-31 of the PAHP contract. They are as follows:

INPATIENT SCREEN URGENCIES
EFFECTIVE OCTOBER 1, 2007

POST STABILIZATION: (1 hour)

If the consumer presents at a hospital that DOES NOT have a psychiatric unit once the person is medically cleared and the screen request has been approved by TMHC the screen **must be completed within 1 hour**. KHS is expecting a good faith effort in meeting this standard. Please remember to document the time you rendered your decision and also the time you completed your screen along with documenting your travel time. KHS will gather that data and use it for any future revisions.

EMERGENT: (3 hours)

If the consumer presents at a hospital that DOES have a psychiatric unit, **but has not been admitted**, once the person is medically cleared and the screen request has been approved by TMHC the screen **must be completed within 3 hours**.

Other Emergent screens include a consumer presenting at a CMHC, nursing home, police station, detention, school, etc.

URGENT: (24 hours)

If the consumer presents at a hospital with a psychiatric unit **and is ADMITTED** to any unit at the hospital and the screen request has been approved by TMHC the screen **must be completed within 24 hours**

KHS recognizes that travel time alone challenges the standard, especially for post-stabilization. Again, the expectation is for a good faith effort and honest documentation of the times involved. KHS will assess the results reported and work with providers without imposing sanctions or other consequences over the next few months

Define PRTF: Psychiatric Residential Treatment Facility

To do a PRTF screen a provider must do the following:

Include standard language from Contract-below is from the contract.

1. Make sure the available resources in the community do not meet the treatment needs of the member.
2. Determine that proper treatment of the Member's psychiatric condition requires services on an inpatient or highly structured level under a physician's direction.
3. The services at a PRTF can be reasonably expected to improve the member's condition.
4. A certification of need must be completed by the team that is independent of the facility. A physician must be involved either through a written letter or participation in the team meeting.
5. There must be an Axis I diagnosis of mental illness.
6. A CBST meeting must be held and documented. This team meeting must be done in the member's county of residence (if not in state custody) or the county of responsibility (if in state custody). This meeting must take place within 7 calendar days of the request.
7. A request for the PRTF screen must be made by calling TMHC for authorization.
8. The screen must be face to face.
9. The results of the screen must be called into TMHC for authorization of payment or denial of payment.

The results of the screen determine whether the youth's PRTF admission will be covered by Medicaid.

This information can be found on pages 32 and 33 of the PAHP contract.

Screening information for PRTF placement can be found in the PAHP contract on Pages 31-34.

25. Will Facility's incident reports be forwarded to KHS?

As outlined in the Provider Manual, KHS needs to be informed of critical incidents that occur at any of its provider's offices and/or locations that involve a KHS Member. Incident reports are not required if the Member is in any type of treatment facility as KHS does not credential facilities and does not manage inpatient or residential care.

26. What is the method/process for reporting critical incidents?

The critical incident form is posted on the KHS website in the "Provider" section. For assistance, contact the Corporate Compliance Department @ 866-547-0222

27. What is the time requirement to report critical incidents to KHS?

Critical incident reports must be reported within 24 hours of becoming aware of the incident.

28. Is the criteria available that will be used for site visits for "high volume providers"?

The Corporate Compliance Department is working to develop guidelines that will be published as soon as possible. For more details contact our Corporate Compliance Department @ 866-547-0222.

29. Does KHS site certification duplicate SRS functions?

No, KHS site visits will be done to oversee compliance with the Provider contract. There may be some duplication with what is reviewed, but the purpose of the KHS visit will be different than the SRS visit.

30. Can charts be either electronic or paper?

Charts can be either on paper or in electronic form. All medical records are expected to be protected as described in the "Confidentiality" section of the Provider Manual on page 50.

31. Will KHS provide standardized forms (informed consent, treatment plans, registration forms, progress, notes, treatment reviews, etc.) to maintain uniformity and avoid becoming non-compliant?

We are not issuing standardized forms now, but a committee will convene to establish elements which must be included on certain forms. This is an ongoing process.

32. Can monthly progress/discharge plan meetings for kids in PRTFs be billed?

CBST meetings are part of concurrent utilization review and are paid as administrative costs.

33. Can TCM be provided by a LMHP professional? How is this approved by the PAHP?

Yes, with regular supervision provided by a LMHP for independent practice.

However, the LMHP cannot provide direct service to the same Member. KHS will approve the LMHP through completion of Case Management certification, KHS Background checks, training, etc...

34. For foster kids, does family input mean biological family?

Biological family, adoptive family, Foster family

35. Who determines "right services" and "right amount"?

Such determinations are guided by practitioner input, clinical practice guidelines and Member needs. Medical necessity drives those determinations. Ultimately, the Consumer and, if possible, input from his/her family should determine proper treatment in collaboration with treatment personnel.

36. Definition of appropriate treatment, standards, best practices, empirically validated?

A full definition of standards can be found on page 22 of the Provider Manual under "Medical Necessity" section "d" Evidence.

37. Plans for measuring outcomes? Criteria? Value? Impact?

KHS has a comprehensive list of performance measures areas entitled performance indicators with specified standards, outlined in Attachment K of the PAHP Contract. The PAHP Contract can be found at www.medicaidtraining.org. The link to Attachment K is at the end of the contract. Aside from this monitoring and reporting system, numerous other functions will be performed. These include activities such as focused studies, consumer satisfaction surveys, Member input, record reviews, assessment of services to persons with special health care needs, assessment of the impact of programs funded for prevention and early intervention programs, and a provider satisfaction survey.

38. Spend down claims not being processed.

Claims covering members on spend-down are not paid until the spend-down levels are met. Provider and Members may contact KMAP to determine current level of spend-down.

39. Claims are being denied as duplicate when there are multiple charges on the same day. The first charge is paid and others are denied. Prior to July 1, we were repeatedly assured that these claims would not be denied as duplicates.

If service is covered then each provider bills under their own NPI and KMAP #. Services then are paid according to the fee schedule.

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Crisis services are not limited to one individual.

40. Are there criteria as to how televideo services must be provided?

No, you still provide your same services and document those services as you would in person. Please see the Provider Manual on Page 77 and 80.

41. Define “Specialized Services” as related to catchment areas.

We no longer divide services by catchment area.

42. What constitutes physician oversight? Presently none is required for private practice, just usual coordination of care with PCP. Does this have to be a psychiatrist? What is physician involvement?

Physician oversight is having a physician available who has competence in diagnosis and treatment of mental illness, preferably a specialty in psychiatry; who reviews the types of treatment offered and is available to provide consultation on a case specific basis as necessary.

All medical services must have a physician’s oversight. All community support services and community based services need a physician for consultation and any program changes. A physician who is a psychiatrist is also, per the PHAP contract, required to be involved in the CBST meeting prior to a PRTF placement.

43. What period of time are benefit limits measured?

Benefit limits will be measured over the Fiscal year beginning 7/1/07.

44. Please provide additional information regarding Peer Support Training.

The cost of basic training, transportation and room and board during training is underwritten by SRS. Additional information can be found on www.trainingteams.org

45. Please provide additional information about Attendant Care Training

Attendant Care training is part of staff certification and is available thru Wichita State University at www.kidstraining.org