



Provider Notice 1.9

January 29, 2008

Provider Manual Changes January 2008

Effective March 1, 2008

- **Page 6 Introduction to Training**

However, Providers may also “attest” to meeting the requirements for these courses at trainings alternate to those provided by KHS with the exception of the Provider Manual Training and the Corporate Compliance/Fraud and Abuse Training. These two need to be done through KHS. Documentation for these alternative courses must be maintained in personnel records on Provider’s site.

- **Page 7 & page 79: Admission/Intake Summary**

ADMISSIONS/INTAKE GUIDELINES

1. Date *
2. Client name *
3. DOB *
4. Gender **
5. ID# *
6. Marital status if applicable **
7. Referral source **
8. Chief Complaint/Presenting Problem *
9. Current symptoms *
10. Current and/or past substance use or dependence and present and/or past mental health and/or substance abuse treatment **
11. Family history of mental health or substance abuse problems. **
12. Level of Education completed and any significant issues regarding school performance or behavior. **
13. Meeting or when met developmental milestones. ***
14. Current or past physical, emotional or sexual abuse. Current or past neglect. Either victim or perpetrator. **
15. Current medications *
16. Mental status (KHS Requirement)
17. Diagnosis to include all 5 Axes. *
18. Treatment Recommendations and response to recommendations **
19. Signature and Credentials of Rendering Practitioner * (Electronic Signature Acceptable)

* denotes a Medicaid requirement

** denotes a KHS suggestion

*** denotes a KHS suggestion for children only

Changes will go into effect 30 days following the date of publication of Provider Notice.

- **Page 8 & Page 80: Treatment Plan**

TREATMENT PLAN GUIDELINES

1. Date (must be completed within 14 days of admission to treatment services and reviewed and updated every 90 days thereafter). *
 2. Consumer name: *
 3. ID #: *
 4. DOB: *
- Special Note: Follow Waiver Guidelines for Members on the HCBS SED Waiver*
5. DSM IV-TR Diagnosis (Axis I and II required): *
 6. Goal(s): *
 7. Treatment Objectives/Action Steps: *
 8. Treatment regimen to achieve objectives. Services or treatment modalities to be utilized (identify what types of services such as therapy, psychotherapy group, parent support, pharmacotherapy etc.): *
 9. Projected schedule for service delivery (daily, weekly, monthly etc...) *
 10. Type of personnel required to deliver the services. *
 11. Projected schedule for review of the beneficiary's condition and updating of the treatment plan. *
 12. Prognosis that has been reviewed and updated within the last 90 days (needs to also be documented within the consumer's chart). *
 13. Special Health Care Needs Status: (KHS Contractual Requirement)
 14. Signature of consumer and clinician/provider or documentation that consumer participated in developing the treatment plan. *

* denotes a Medicaid requirement

** denotes KHS suggestion

Note: If you are working at a Community Mental Health Center you will still need to know your licensing requirements and any other credentialing requirements that your center may have obtained.

- **Page 8: Progress notes for each contact must include the following:**

- * Symptom assessment (Effective March 1, 2008)
- * Service provided and linkage to goals
- * Provider of the service
- * Review of medication regime, if applicable
- * Progress assessment/client response
- * Date of contact
- * Start time and duration (Effective March 1, 2008)
- * ~~Duration of Service~~ (Effective March 1, 2008)

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Treatment Planning

Providers are required to notify members, in writing, of any decision to terminate or reduce services within five (5) working days of the date of the decision. It is suggested that providers use the 'certified – return receipt requested' service available from the US Postmaster.

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Section 7:

Kansas Health Solutions Corporate Compliance Plan and Suspected/Substantiated Fraud and Abuse

Kansas Health Solutions is committed to ensuring that KHS Staff, Subcontractors and Network Providers perform administrative services and deliver behavioral health care in a manner reflecting compliance with statutes, regulations and contractual obligations. Further, KHS is committed to fulfilling its duties with honesty, integrity, and high ethical standards for the delivery of a comprehensive, statewide Prepaid Ambulatory Health Plan. KHS supports the government in its goal to decrease financial loss from false claims and has, as its own goal, the reduction of potential exposure to criminal penalties, civil damages, and administrative actions.

In the context of the KHS Compliance Plan, fraud is considered an act of purposeful deception or misrepresentation committed by a person or behavioral health provider to gain an unauthorized benefit. Abuse committed by a behavioral health provider means activities that are inconsistent with standard fiscal, business, or medical practices that result in unnecessary cost to a government health care program or other health care plan, or that fail to meet professionally recognized standards for health care. Abuse can also include beneficiary practices that may result in unnecessary cost to the Medicaid program. The KHS Compliance Program also has a role in assuring quality as a cornerstone of value for government Medicaid payments for healthcare services.

The Kansas Health Solutions Corporate Compliance Plan and associated training is posted on our website at www.kansashealthsolutions.org. Familiarity with and adherence to the plan and completion of training is required of all Kansas Health Solutions staff, subcontractors, network providers and their staff.

Additionally, Kansas Health Solutions has established a statistically valid sample review processes to assist in the ongoing monitoring of UM data, on-site review results, and claims data review. Providers will have over and under-utilization reviews performed through the use of outlier reports and regular utilization reports and analyses. Such data is used to monitor: overall program integrity, including appropriate use of practice guidelines, cross system utilization practices and patterns, coverage/authorization decisions and denials, and the quality and appropriateness of care furnished to members with special health care needs.

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The hotline number is 1-866-547-0222 and operates between the hours of 7:30 AM and 5:00 PM, (Effective February 1, 2008) Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer. However, it is KHS' policy that neither KHS nor the provider may retaliate against anyone who identifies oneself and reports any incidents or suspicion of Medicaid fraud or abuse.

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Outpatient Registration Process: The following were added to the list -
CAFAS/PECFAS data collection (If applicable)
Ethnicity

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CRISIS SERVICES GUIDELINES

When to bill a Crisis Service code:

1. The eligibility for crisis services is as follows:

- a. All individuals who self-identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

As a general rule, all the crisis service codes should be utilized if a person has psychiatric symptoms that are interfering with their functioning to the point that they can not do daily life functions and without intervention would immediately be at risk for higher level of care such as hospitalization or other out of home placement. Members may also self-report that they are in crisis or in need of an initial crisis intervention. This service can be provided without having face to face contact with a QMHP or KHS-designated LMHP. If the Member is new to the CMHC and the person to provide the crisis intervention is not a QMHP or KHS-designated LMHP then phone contact is required with a QMHP or KHS-designated LMHP to determine if a screen is needed or if to proceed with crisis services.

2. Crisis Intervention and Stabilization Provided by an Attendant:

Crisis Intervention-Emergent-Attendant is when a Member needs to have an Attendant Care worker with them because of an inability to regulate their behavior without the assistance of another person. The attendant care worker will assist with de-escalating the crisis and will provide support with maintaining the person in their home and community. This type of intervention may occur when assistance is needed to stabilize a person prior to an emergent screen, during a screen, or immediately following a screen. This is short term and should not exceed 6 hours per episode per provider.

Crisis Stabilization-Ongoing-Attendant care is when without the assistance of an Attendant Care staff to assist in daily personal living the person will go back into a crisis state. This is short term in nature and should not exceed 66 hours per episode.

Crisis Intervention and Stabilization provided by an Attendant should not exceed 72 continuous hours.

3. Crisis Intervention and Stabilization Provided by a Bachelors Level Provider:

Crisis Intervention-Emergent-Bachelors is the same as above, but it is felt that a person with more clinical skills is needed in order to provide more symptom reduction services rather than simply supportive services. This is short term and should not exceed 6 hours per episode. Billing should not exceed this amount of time.

Crisis Stabilization-Ongoing-Bachelors is the same as Crisis-Stabilization-Ongoing Attendant Care only a more skilled or higher trained person is needed in order to help reduce symptoms. This is short term in nature and should not exceed 66 hours per episode. Billing should not exceed this amount of time.

Crisis Intervention and Stabilization provided by a Bachelors level person should not exceed 72 hours.

This is not required to be provided continuously and can be spread across the duration of the episode. Billing should not exceed this amount of time.

Crisis Intervention and Stabilization provided by a Bachelors level person should not exceed 72 hours. This is not required to be provided continuously and can be spread across the duration of the episode. Billing should not exceed this amount of time.

4. Crisis Intervention and Stabilization Provided by a LMHP.

Crisis Intervention-Emergent-LMHP is the same as above only if it is felt that a Clinician's skills are needed in order to provide a higher level of clinical intervention. This is a face to face intervention. This would include a preliminary assessment of risk which may include a mental status, and the need for further evaluation or other mental health services. Which includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level. This also includes a clinician utilizing specific treatment interventions such as cognitive behavioral therapeutic techniques or other techniques that only a clinician who has had a higher level of training order can provide.

5. Crisis Services can be billed concurrently for the purpose of safety of the consumer and staff when the rules listed below are followed:

- a. Emergent Crisis Interventions at all levels can be billed concurrently with Emergent Crisis Intervention provided by a second staff member for the first 3 hours of the crisis intervention.
- b. Ongoing Crisis Stabilization provided by a Bachelors level provider or an Attendant Care Provider can be billed concurrently with a second staff member for up to the first 24 hours of the crisis episode.
- c. Each episode must be face to face. The ongoing intervention for Crisis Services can not exceed 14 days.

6. All documentation in the chart must reflect the actual crisis, what interventions were used, the Member's response to the interventions, family involvement and when the crisis is resolved. (An outline for documentation of all levels of interventions for these codes can be found below).

7. Generally crisis interventions should not be billed post discharge from an acute care hospitalization as the person is to have been stabilized.

8. An episode is defined as the initial face to face contact with the beneficiary until the current crisis is resolved, not to exceed 14 days. The beneficiary's chart must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within seven calendar days of a previous episode, it shall be considered part of the previous episode, and a new episode will not be allowed. This means that 21 days after the initial onset of a crisis episode a new episode can not be billed for until the 22nd day or later after the initial episode. If a person goes back into crisis before the 21 days and after 14 days of the onset than the treatment team may want to consider a higher level of care. Other non-crisis services can be billed during the period between day 15 and day 21.

A new episode is determined by a lapse in time. Once it has been 21 days and now is the 22nd day or later after an episode a new episode may occur and be billed for even if it is the same problem.

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DOCUMENTATION REQUIREMENTS FOR CRISIS SERVICES

1. Start time and duration *
2. Needs to list all participants during the service (family, LLE, or other staff). *
3. Must have a summary of what the crisis is or the symptoms that indicate the person is in a crisis. **

4. Must have a goal which could be assess and/or stabilize (this could also not be in a treatment plan if Member is new to services or a new problem) being worked toward that will reduce the symptoms that are causing the crisis. *
5. Must have overall content of session/s. **
6. Needs to have a brief mental status (clincians/LMLPs only). A brief mental status should include, but not be limited to mood, affect, orientation and thought content. **
7. Needs to have a response to treatment section *
8. Needs to have a plan for what will be worked on with the Member and how for ongoing crisis interventions. This needs to include a crisis plan in case things escalate. **
9. There needs be listed out what other services will be utilized to help the Member and when those services are to take place. **
10. Documentation demonstrates the staff person is assisting the beneficiary with regaining or maintaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnosis, or treatment with his or her clinician. *
11. Documentation demonstrates that the staff person is assisting the beneficiary to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments. *
12. Resolution of the crisis must be clearly documented. *

**denotes a Medicaid requirement*

***denotes a KHS requirement*

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Clarification On Early Childhood Services and Appropriate Billing for Those Services

At this time KHS reimburses for two mental health assessments per fiscal year. These assessments must include observation. The provider manual outlines the qualifications of a person that can provide this service. That outline is as follows:

Mental Health Professional licensed to practice independently:

licensed psychologist
 licensed clinical marriage and family therapist,
 licensed clinical professional counselor,
 licensed specialist clinical social worker, or
 licensed clinical psychotherapist.

And a Mental Health Professional licensed to practice under supervision or direction:

licensed masters marriage and family therapist,
 licensed masters professional counselor,
 licensed masters social worker, or
 licensed masters level psychologist.

And a physician, or a physician assistant or advanced registered nurse practitioner (ARNP) working under protocol of a physician.

Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All services must be rendered within the scope of the provider's professional license.

Core Competencies are in development. As these become available KHS will provide that information. At this time persons providing these services must have experience and a background in working with this population and be able to demonstrate their experience. Ways to demonstrate competence in working with children 0-5 could be through CEUs, Vita and/or work history.

In order to provide and bill for Early Childhood Mental Health/Behavioral Health Assessments for infants/children ages 0 through 5 years the following criteria must be met by the consumer:

For children 0 through 3 years of age, the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–3) for assistance in determining the infant or child’s diagnosis is encouraged.

A child qualifies for assessment if anyone has a concern or has identified a child at risk. The use of the assessments is to determine the need for mental health treatment.

In addition, during the assessment process an established assessment tool must be utilized which could include, but is not be limited to the CBCL (Child Behavioral Check List), the PECAFAS (Preschool Early Childhood Functional Assessment Scale), or the Devereux Early Childhood Assessment tool (DECA).

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DOCUMENTATION REQUIREMENTS

1. All assessments/evaluations need to be documented and include the following:
 - a. Reason for referral and referral source.
 - b. Documentation that informed consent was obtained from the parent or legal guardian if this has not already been obtained.
 - c. Date, DOB and ID#
 - d. Start Time and duration
 - e. DSM IV - TR Diagnosis for QMHP’s or KHS designated LMHP’s.
 - f. If possible, document for children 0-3 a Diagnosis from the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. However, when billing use the standard DSM-IV diagnosis for QMHP’s or KHS designated LMHP’s.
 - g. Observations
 - h. Developmental history
 - i. What tools administered. A formal summary of the results.
 - j. Recommendations.

NOTE: The above are all KHS requirements for documentation

Please make changes to your current Provider Manual or you may visit our website at www.kansashealthsolutions.org and download the revised version or contact Diane Denham at 1.866.547.0222 or e-mail dianed@kansashealthsolutions.org and one will be mailed to you.

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