



Provider Notice 2.7

January 30, 2009

» **Adult Psychiatric Rehabilitation Service Eligibility Worksheet**

The Psychiatric Rehabilitation Service Eligibility Worksheet has been updated. The only requirement change to the form is that it must be done, at a minimum, annually upon re-evaluation for eligibility for rehabilitation services. As a reminder, this worksheet is to be done on Members who do not meet the criteria for SPMI, but could benefit from rehabilitation services. This worksheet must be completed by a QMHP from a Community Mental Health Center (CMHC) or a CMHC subcontractor, and must be maintained in the Member's medical record. Prior authorization is not required. Please direct any questions to the Clinical Department. A hard copy of this new form is enclosed with this notice.

Carol Neeley, MSW, LSCSW
Clinical Director

» **Targeted Case Management**

- **Effective immediately** - Providers may deliver both Targeted Case Management (TCM) and any other service direct or indirect to the same Member.
- Targeted Case Management/TCM is to be provided in a manner that is consistent and meets the needs of the Member, is driven by the Member's self identified goals and will not restrict the Member's access to other services under the plan.
- Member's may participate in Targeted Case Management/TCM services solely without demand to participate in other Medicaid Mental Health Services, or can choose to receive other Medicaid Mental Health services without demand to participate in Targeted Case Management/TCM services.
- All persons providing Targeted Case Management/TCM **must** receive regularly scheduled clinical supervision from a person meeting the qualifications of a QMHP or a LMHP approved by KHS.
- Providers of Targeted Case Management/TCM services **cannot** and **shall not** deny provision of other Medicaid services, only the Department of Social and Rehabilitation Services has the authority to authorize or deny access to services under the plan.

Payment:

Payment for Targeted Case Management or other services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

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

Limitations:

Caseload size must be based on the needs of the Members/families with an emphasis on successful outcomes and Member satisfaction and must meet the needs identified in the Treatment Plan/Plan of Care. The following general ratio (Full time equivalent (FTE) to Medicaid eligible's) should serve as a guide: 1 FTE to 20 eligible's dependant on the frequency and intensity of services provided to the Members.

*Carol Neeley, MSW, LSCSW
Clinical Director*

» **Crisis Services**

Effective March 1, 2009 there will no longer be time frames around how long a crisis service plan may continue. Crisis services at any level may be provided as short or as long as needed in order to stabilize the Member or refer to a higher level of care. All service provider levels of crisis services are not identified by education, but rather by service type. This means Crisis Attendant Care, Crisis CPST, and Crisis psychotherapy. These services are open to Community Mental Health Center providers. Enclosed are the new crisis services guidelines and guidelines for documentation for these services. Please direct any questions you may have regarding these services to Carol Neeley at 785-575-9373 or cneeley@khs-ks.org.

*Carol Neeley, MSW, LSCSW
Clinical Director*

» **Border City Providers**

Effective February 1, 2009, licensed mental health practitioners (LMHPs) providing services within the border city designation (when a provider is located in a state other than Kansas, and services are rendered in that state, cities within 50 miles of the Kansas border are considered Border Cities. See KMAP Provider Manual for more details) will be allowed to enroll with KMAP for the provision of services for the Pre-Paid Ambulatory Health Plan (Kansas Health Solutions). This enrollment will not require Kansas licensure; however, the provider must meet the licensing requirements of the State in which they are performing the service.

For a complete Provider Enrollment Packet, please contact Michele Johnson by calling 866.547.0222 or e-mail mjohnson@khs-ks.org.

Michele Johnson, Director of Provider Network

» **Care Coordination**

In the coming months, KHS will begin offering KHS Care Coordination to Members with Special Health Care Needs who have been diverted from hospitalization (private, state, KVC-Star) or PRTF. In order to facilitate this process, KHS will need to know the outpatient appointments included in the diversion plan. As of March 04, 2009, when a screener calls a diversion result to the KHS Call Center, the Call Center

staff will ask for the specific appointment information, including date, time, and provider. If the screener does not have access to specific appointments during the completion of the screen, the Call Center staff will document what information is available, including the disposition, and will ask the screener to call back within 1 business day with the actual appointment times.

Michael Leeson, M.D., Ph.D.
Chief Medical Officer

» **KHS Provider Information Update Form (Effective March 1, 2009)**

When network providers need to update or add an address to a practice, please submit the KHS Provider Information Update Form and include a new Site and Service Availability Form. This forms tells us what services will be provided at the new location and hours of availability.

Please fax the forms to the KHS Provider Network Department at 785-232-2610.

Michele Johnson, Director of Provider Network

» **CPT Code Change Effective Immediately**

Effective January 1, 2009, CMS changed the CPT code for one of the KHS covered injection. CPT code 90772; Ther/proph/dia inj,sc/im; has been changed to CPT code **96372**. Please adjust all billings for this service. This change is effective immediately.

Steve Richards, Chief Financial Officer