



KANSAS HEALTH SOLUTIONS

Provider Notice 2.9

May 1, 2009

» **Authorizing 1915(b) Services in the New Benefit Year**

KHS has refined the process for authorizing 1915(b) services in transitioning into the new benefit year which begins 7/1/09. During the dates 6/26/09 through 8/31/09:

- The policy of backdating 1915(b) authorizations one business day will remain in effect. However, for members with open and approved 1915(b) authorization plans, Providers will be allowed to enter new authorizations from 6/26/09 until 8/31/09. This is a one time authorization.
- All authorization plans will expire on 6/30/09.
- All members with an authorization plan ending 6/30/09 will be eligible for a new authorization plan (up to 1000 units for Attendant Care and 16 units for Case Conference) with a start date of 7/1/09 (when the plan is entered within the above listed timeframe). A list of eligible members will be posted on ProviderConnect on 6/22/09. Please note that any authorization plan created between 6/22/09 and 6/30/09 (inclusive) will not be on this list but will still require a new authorization beginning 7/1/09.
- When you enter your authorization plan please remember that ProviderConnect automatically defaults to the date you are entering your information. You will need to make sure the start date of the authorization plan is 7/1/09.
- Please do not submit claims until your authorization plan has been approved. If a Provider submits a claim before the authorization plan is approved and the claim is denied, that Provider is responsible for resubmitting the claim once the authorization plan has been approved.
- During this timeframe, please use ProviderConnect to check on the status of your authorization plan(s). Any paper versions submitted to Care Management will be processed after completion of electronic submissions.

*Lori Libel LSCSW, AAPS
Manager of HCBS Waiver Services and Care Management*

» **ProviderConnect Updates (Effective Immediately)**

KHS recently implemented upgrades to eCura to improve Provider claim submission and system performance. These changes are effective immediately.

- **Provider Connect Entry of COB Claims-** COB claims can now be submitted through provider connect. If you would like training please call KHS Provider Representatives Becky Schuetz at 785-291-9179, or Daniel Dubois at 785-291-9633.

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

- **Claims for services that require prior authorization denying for “Dates of Service Not Authorized”**
– Previously, when a claim was submitted for a CPT code that requires prior authorization it was not always getting matched to the approved authorization and was resulting in denials for “Dates of Service Not Authorized”. New claims submitted for services that require prior authorization should no longer deny for this reason when an appropriate authorization exists.

CPT codes impacted:

Case Conference: 99366, 99367, 99638

1915(b) Attendant Care: T1019 HE

SED Waiver Services: T1019 HK, T2038, S5110, S9485, S5150, H2021

PRTF Waiver Services: T1019 HK, T2038, S5110, S9485, S5150, H2021, T2038 U1, H2025

KHS has identified inappropriately denied claims and will reprocess them. If you continue to receive this denial, please ensure you have an authorization for the claimed procedure code or the authorization on the claim is correct for the date of service.

- **PC Claim form validation for Dx Code Pointers** – Previously, ProviderConnect allowed users to submit a claim without a Dx pointer checked on each service line. Now a Dx pointer is required for each service line. A new warning message will display after clicking on Confirm if there is not a diagnosis pointer on the claim detail line – “At least one Diagnosis Pointer in Box 24E must be entered”.
- **PC Claim Search Modification and Message** – In an effort to increase the performance of ProviderConnect, a modification has been made which limits claim searches to only display results of 1000 or less. Searches greater than 1,000 claims will receive this message in the Claim Search Module; More than 1000 claims of the same type match the specified search criteria, please re-define the search criteria. Resubmit your search for a smaller date range.
- **PC Online Adjustments – Box 31** – When editing a claim that had a rendering provider and the rendering provider was removed, the claim was saved with the original rendering provider still displaying in box 31. Now edited claims where the rendering provider has been removed, no longer displays the rendering provider.
- **CPT Code T2038- No Unique Level of Care (LOC)**
The issue with CPT code T2038 receiving exceptions for “No Unique Level of Care (LOC) was available for selected CPT code” has been fixed. KHS has completed the re-batch of the claims that received this exception. If you continue to receive this exception for T2038, please ensure you have submitted the appropriate authorization number on your claim.
- **Provider Support**
If you continue to experience difficulties with these changes and are unable to determine the cause, please contact Becky Schuetz at 785-291-9179, or Daniel Dubois at 785-291-9633 for help in resolving your issue.

Jennifer Roberts, Claims Manager

» **Home Based Family Therapy (HBFT)**

KHS would like to clarify the need for Home Based Family Therapy Training that allows practitioners to bill the HK Modifier for CPT Code 90847 – Family Psychotherapy.

Any licensed practitioner may bill CPT CODE 90847 (Family Psychotherapy) at any time. If the practitioner chooses to bill CPT CODE 90847-HK: (Family Psychotherapy with Member present provided in the home or community) he/she must declare the intent to take the additional training by one of the three approved ways:

1. Attend the approved KSU training on the dates offered by KSU;
2. Submit an alternative training curriculum to KHS which sufficiently addresses core competencies required to provide HBFT;
3. Submit to KHS provider specific information in the form of a Curriculum Vitae, demonstrating your existing experience and knowledge that reflect the core competencies required to provide HBFT.

A practitioner may provide HBFT using the HK modifier for one year following declaration of the intent to complete the training and the actual completion date.

For questions about this process, please contact Lorna Clarke or Michelle Wilson Skinner at 866-547-0222.

A practitioner may declare the intent to take the HBFT Training by completing the KHS Credentialing Application (Revised 6/1/09) page 2 under the section Licensure, Certification(s), Registration section or the Provider Information Update Sheet. The section under Clinical Subspecialties (which asks for a potential training completion date) must also be completed. (See enclosed form)

Effective July 1, 2009, KHS will only accept the June 1, 2009 revised Credentialing Application which requires this information. The KHS Credentialing Application is located on the KHS website (www.kansashealthsolutions.org) or call the KHS Credentialing Department for a copy.

Michele Johnson, Director of Provider Network

» **SED Waiver/PRTF CBA Grant**

The following changes to previous policies relates only to CMHC's and their subcontractors. Based on the audit reviews and authorization process, KHS and SRS staff have identified several issues that need clarification. All KHS Members with a Family Choice Date of 6/1/09 or after will be held to these changes for auditing and authorization purposes. A field will be added to Lucidity for the clinical eligibility date to be entered.

Effective June 1, 2009 the following will be in effect for the SED Waiver and PRTF CBA Grant:

- According to Medicaid Federal statutes 42 CFR 438.210(d)(1) and 42 CFR 438.404 (d)(1) the notice of action must be provided to the Member within 14 days of eligibility determination.
 - * The notice of action for SED Waiver Members must be provided within 14 days of the completion of the Initial Clinical Eligibility Packet (ICEP).
 - * The notice of action for PRTF CBA Grant Members not residing in a PRTF, who receive a PRTF screen as part of determining eligibility, must be provided within 14 days from the screen date.
 - * The notice of action for PRTF CBA Grant Members discharging from a PRTF must be provided 14 days from date of discharge from the PRTF.
 - * **The exception to the above scenarios is when an exception for an age or CBCL score (SED Waiver only) is requested. The date the exception is granted is considered the date that eligibility is determined.**
 - * For the SED Waiver and the PRTF CBA Grant the notice of action must be provided to the Members within 14 days of completion of the annual review.
- Timeframe to sign Family Choice Document.
 - * For SED Waiver Members, the Family Choice Assurance Document must be signed within 14 days of completion of the ICEP.
 - * For PRTF CBA Grant Members who are diverted from PRTF placement the Family Choice Assurance Document must be signed within 14 days of the screen date. If for any reason this is not possible the reasons must be thoroughly documented.
- CBCL is to be completed no more than six months prior to the completion of clinical eligibility in order to be considered valid.
 - * For the SED Waiver that date is the ICEP.
 - * For the PRTF CBA Grant Members who are diverted from PRTF placement that date is the screen date.

This is based on the validity of the CBCL tool. If the date of the CBCL is more than six months from the date of completion of the ICEP for SED Waiver members or from the screen date for PRTF CBA screen members who are diverted, the establishment of eligibility will be considered incomplete and must be re-established.

- The CAFAS is to be completed no more than three months prior to the completion of the ICEP in order to be considered valid for SED Waiver Members. The CAFAS can be completed no more than three months prior to the completion of the screen in order to be considered valid for PRTF CBA Grant Members who were diverted from PRTF treatment. If the date of the CAFAS is more than three months from the date of completion of the ICEP or PRTF screen, the establishment of eligibility will be considered incomplete and must be re-established.
- The initial Plan of Care must be completed within 30 days of the Family Choice Date. The “official” date is established by the date the family signs the Plan of Care.

- An ARNP may sign the Plan of Care in lieu of a Physician.
- School age children, defined as being age 5 or older, are required to sign their Plan of Care at the initial and annual plan of care review. If for any reason the child does not sign the Plan of Care, the reasons need to be thoroughly documented.
- If the 3160 was submitted to SRS in a timely manner (15 days), allowing SRS 45 days to process, but eligibility is not received until more than 60 days after the FCD; the Provider has 2 weeks to enter the ePOC from the time eligibility approval is received without being affected by a 60 day rule. However, if the provider sends in their 3160 on the 16th day or after, the provider has not allowed SRS the minimum required time of 45 days to process the eligibility. In some cases this delays financial eligibility. Unless there is a well documented reason for the delay in sending the 3160 to SRS the 60 day rule will apply.

Thank you for your continued commitment to children and families. Your dedication to these Members will continue to strengthen and support the State of Kansas SED Waiver and PRTF Grant programs. Please feel free to contact us with any questions.

*Lori Libel LSCSW, AAPS
Manager of HCBS Waiver Services and Care Management*

» **Medicaid ID Change Effective June 1, 2009**

Effective June 1, 2009, claims will no longer be accepted when submitted with the patient's Social Security Number, except when billed with procedure codes I0010, I0020, or W0010.

Previously, claims submitted electronically with the patient's Social Security Number were accepted and processed by KHS. After June 1, 2009, KHS will no longer accept the Social Security Number in box 1a, except for inpatient screens or CBST services. Providers that submit claims in ProviderConnect will notice that the Medicaid ID is automatically populated to box 1a of the 1500 claim form. When submitting claims in an 837 format, providers will need to submit the patient's Medicaid ID number in Loop 2010 BA in segment NM109.

Jennifer Roberts, Claims Manager

» **Timeliness of First Mental Health Service Following Discharge from a Psychiatric Inpatient Setting**

The KHS network has struggled to meet our contractual obligation for timeliness of first mental health service following discharge from a psychiatric inpatient setting. Research clearly shows that Members who receive post-discharge services are less likely to be readmitted than those who do not. However, we also recognize that Providers have a limited amount of influence over whether or not Members engage in services following discharge in a timely manner. Accordingly, KHS and SRS have negotiated a change that will allow monitoring to reflect Provider's attempts to engage the Member rather than actual follow-

through by the Member.

The prior contractual arrangement between KHS and SRS included a standard that 85% of Members discharging from a mental health inpatient facility would receive treatment services within 72 hours of the discharge, 90% would receive such services within 7 days of the discharge, and 95% would receive such services within 10 days of discharge. Our most recent performance statewide was 75% at 10 days, which reflects that greater than 50% of Providers could be subject to corrective action if no changes were made.

Beginning July 1, 2009, this indicator will change as follows. Providers will be expected to begin attempting and documenting outreach contact with Members following discharge, with goals of offering and encouraging attendance at follow-up appointments as well as determining if the Member's clinical status warrants an appointment sooner than what has been scheduled. Monitoring will focus on the first attempted contact by the Provider, on the condition that the Provider either successfully contacts the Member, completes 3 unsuccessful attempts to contact the Member, or provides a clinical service to the Member within 10 days of the discharge. If the Member is seen for a clinical service by the Provider within the first 72 hours after inpatient discharge, this may be counted as the initial contact; if the Member is not seen within the first 72 hours following inpatient discharge, the expectation would be that outreach attempts will have commenced by 72 hours following the inpatient discharge. The performance standard for this indicator will be that 85% of initial contacts or services will occur within 72 hours of discharge, 90% will occur within 7 days of discharge, and 95% will occur within 10 days of discharge. Monitoring of this standard will be by a random sampling audit method, with the sample drawn from the pool of discharges for which KHS has an actual discharge date. Providers will be asked to submit documentation of their outreach attempts and/or service provision (if claims data is not available) for any of their Members selected in the random sampling.

KHS will not dictate the format of documentation of outreach attempts. As an illustration, though, the following example outreach log would be fully adequate:

Member Name: Xxxx Yyyyyyy		Member ID Number: 00000000	
Hospital Discharge Date: 03/31/2009			
Date	Outreach or Clinical Service	Outcome	Staff Signature
4/1/09	Telephone Outreach Attempt	No answer	(signature)
4/3/09	Telephone Outreach Attempt	No answer	(signature)
4/5/09	Telephone Outreach Attempt	Member said he was doing well and would be at his appointment tomorrow.	(signature)

We realize this change may necessitate significant process changes for Providers, and we apologize for any inconvenience. This change was necessary to move KHS toward compliance with our contract with SRS. If you have any questions about this change, please feel free to contact Michael Leeson, M.D., Ph.D. at KHS.

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