2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary

KanCare Program

Chapter 13: Long Term Care

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UnitedHealthcare® Community Plan

Welcome to UnitedHealthcare Community Plan

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as how to process a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic tools on our website at **UHCprovider.com**.

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to **UHCprovider.com**. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.

If you have questions about the information or material in this manual, or about our policies, please call Provider Services.

Important Information about the use of this manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Participation Agreement:

In this manual, we refer to your Participation Agreement as “Agreement”.

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Chapter 13: Long Term Care

KanCare Home and Community Based (HCBS) Program

13.1 Introduction

The KanCare HCBS Program is a Medicaid long-term delivery system which fully integrates traditional physical health, behavioral health and nursing facility based services, with Home and Community Based Services (HCBS). This integration ensures a full continuum of services for Medicaid members through a Managed Care Organization (MCO). The state of Kansas now fully integrates these services into the MCO and no longer directly administrates these valuable services for the HCBS programs outlined in the section below.

The Home and Community Based Services (HCBS) programs are designed to meet the needs of beneficiaries who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution. All HCBS services require prior authorization through the Person-Centered Service Plan (PCSP) process.

The collective goals of the KanCare HCBS Program include:

- Integrated, whole-person care.
- Preserving or creating a path to independence.
- Alternative access models and an emphasis on home and community based services.

These goals can be accomplished through the systematic process of assessment, planning, coordinating, implementing, and evaluating a member's care by care coordination. Fully integrated care coordination ensures that the recipient's acute/chronic physical health care, behavioral health care, and HCBS program services are provided in a seamless, cohesive, and collaborative manner reducing waste, duplication, and redundancy in services. Care coordination not only provides the recipient with a concierge to facilitate scheduling and service access; it also provides the recipient with an advocate that assists the member in gaining needed knowledge of services and alternatives to make the most informed decision related to health care and custodial services.

Disability Sensitivity

Each health plan and its providers must comply with the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. Health plans and their providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

We must reasonably accommodate persons and shall ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. This is accomplished by written policies and procedures to assure compliance while ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services.

13.2 Overview of KanCare HCBS Programs

The state of Kansas now fully integrates the Home & Community Based Services (HCBS) for the Autism, Frail and Elderly, Physical Disability, Technology Assisted, Traumatic Brain Injury, Serious Emotional Disturbance and Intellectual/Developmental Disability Programs into KanCare. While no longer directly administering the valuable services for these HCBS programs, the state of Kansas retains authority and oversight of these programs.

Eligibility for all of the HCBS programs is determined by the state or state designees.

Autism Program

A child can be offered a position for Autism Program services between the time of an Autism diagnosis through their fifth year of age. Once an offer has been made, the child may receive up to three years of Autism services with an optional 4th year, depending on the child's clinical needs.

Frail Elderly Program

The Frail Elderly Program serves individuals age 65 and older who want community based services as an alternative to nursing home care.

Physical Disability Program

The Physical Disability Program serves individuals age 16 through 64 who are physically disabled and need assistance with activities of daily living who want community based services as an alternative to nursing home care.

Technology Assisted Program

The Technology Assisted Program serves individuals who are age 0 through 21 years, chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function and require substantial and ongoing daily care by a nurse, comparable to the level of care provided in a hospital setting, or other qualified caregiver under the supervision of a nurse to avert death or further disability. Furthermore, the individual is hospitalized or at imminent risk of hospitalization, whose illness or disability, in the absence of home care services, would require admission to a hospital.

Traumatic Brain Injury Program

The Traumatic Brain Injury Program serves individuals age 16 to 65 who have sustained traumatic brain injury.

Serious Emotional Disturbance Program

The Serious Emotional Disturbance Program serves individuals ages four to 18 who experience serious emotional disturbance and who are at risk of inpatient psychiatric treatment. There are exemptions for children younger than four and extension of services up to the age of 22.

Intellectual/Developmental Disability Program

The Intellectual/Developmental Disability program serves individuals age five and older who meet the definition of intellectual or developmental disability.

13.3 Work Opportunities Reward Kansans (WORK) Program

UnitedHealthcare Community Plan also coordinates services covered under the WORK program. For specific criteria regarding the WORK program, please reference the Kansas Medical Assistance Program (KMAP) WORK manual.

All WORK services require prior authorization through the member's UnitedHealthcare Care Coordinator.

13.4 HCBS Provider Responsibilities

HCBS Providers will provide services in accordance with the Person-Centered Service Plan including the amount, frequency, duration, and scope of each service in accordance with the member's service schedule.

HCBS providers utilizing Electronic Visit Verification (EVV) will use the EVV system to submit claims. All other HCBS providers will file claims according to the options listed in the claims filing portion of this manual. Requirements regarding use of EVV can be found in Section 13.9, the Electronic Visit Verification section of this manual.

HCBS providers will follow the Documentation Requirements for each HCBS program service as defined in the applicable Kansas Medical Assistance Program (KMAP) Provider Manual.

13.5 Provider Credentialing/Verification

We follow the provider requirement guidelines defined in the Kansas Medical Assistance Program (KMAP) Provider Manuals to credential nursing facility providers and providers of HCBS services.

We utilize the state-approved standardized credentialing application.

Initial Verification/Credentialing: The initial verification/credentialing process shall include verification of required documents as outlined in the KS Facility/Provider – Initial and Re-credentialing Application in addition to provider requirements as defined by the state. All providers must submit the Certificate and/or Licensures as applicable to the services they are providing and each license will be verified with its issuing licensing board. Each provider will provide proof of general liability insurance that meets the minimum required amount set by the state of Kansas as applicable to the services each provider is contracting to provide. Providers will also provide proof of malpractice insurance, as applicable, as required by state guidelines.

HCBS providers are not required to maintain malpractice insurance unless required to do so per state provider requirements or applicable provider licensing requirements.

On-Site Review: All care provider applicants will adhere to an on-site review performed by Kansas health plan staff. This will be required with initial provider enrollment, and continued every three years with re-verification/credentialing of all network providers.

If a provider does not meet all sections in the On-Site Review tool, approval for contracting will be reviewed by executive management for acceptance into network.

On-Site Review may be waived during initial verification/credentialing and/or during initial network development upon state direction.

Re-Verification/Credentialing: Every three years, all providers will be re-verified/credentialed unless otherwise specified. This process includes meeting all initial requirements of this verification/credentialing process and may be subject to review of history of potential quality of care/quality of service concerns within the re-credentialing cycle.

If a care provider applicant fails to meet the verification/credentialing requirements, the applicant will be denied and notified in writing. An applicant has the right to appeal an adverse decision within 30 days of notification. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the decision.

HCBS Provider Qualification Review: We verify that all HCBS care providers are in compliance with the qualifications listed in the current and approved waiver issued by the state. The care provider is subject to qualification compliance at the time of initial credentialing with us. Participating HCBS providers are subject to a Qualifications Review every 365 days.

13.6 Home and Community Based Services

The following table is a summary of the HCBS services, including benefit limitations, unit definitions, billing codes and required diagnosis codes (when applicable). Where a diagnosis code is noted, it must be the primary diagnosis code billed on the claim.

Providers always need to reference the member's Person-Centered Service Plan for specific information regarding authorized procedure codes and authorized units for each service.

If the diagnosis (DX) in the grid below indicates "na", providers must bill the appropriate diagnosis for the service being provided. A valid diagnosis is required on all claims.

Autism Program

Benefit Description	Limits	HCPC	DX
Family Adjustment Counseling	Max 48 units per calendar year	S9482 (Ind) S9482HQ (Grp)	R68.89
Parent Support & Training	Max 120 units per calendar year	T1027 (Ind) T1027HQ (Grp)	R68.89
Respite Care	Max 672 units per calendar year	T1005	R68.89

Frail Elderly Program

Benefit Description	Limits	HCPC	DX
Adult Day Care, Half Day	1 unit equals 1- 5 hours Limited to 1 unit per day	S5101	R68.89
Adult Day Care, Per Diem	1 unit equals more than 5 hours Maximum of 1 unit per day	S5102	R68.89
*** Assistive Technology**	1 unit equals 1 purchase $7,500 lifetime max	T2029	R68.89
Personal Care Services – Provider Directed	1 unit equals 15 minutes Max 48 units (12 hours) per day Service not paid while in hospital or Nursing Home	S5130	R68.89
Personal Care Services – Provider Directed	1 unit equals 15 minutes Max 48 units (12 hours) per day Service not paid while in hospital or Nursing Home	S5125	R68.89
Personal Care Services – Provider Directed	1 unit equals 15 minutes Max 48 units (12 hours) per day Service not paid while in hospital or Nursing Home.	S5125UA	R68.89
Personal Care Services – Self Directed	1 unit equals 15 minutes Max 48 units (12 hours) per day Service not paid while in hospital or Nursing Home or Assisted Living Facility	S5125UD	R68.89
*** Comprehensive Support – Provider Directed**	1 unit equal 15 minutes Max 48 units (12 hrs) per day Cannot exceed 24 hours w/ other waiver combo Service not paid while in hospital or Nursing Home or Assisted Living Facility Cannot be provided at same time as Personal Care Services or Enhanced Care Service	S5135	R68.89
*** Comprehensive Support – Self-Directed**	1 unit equals 15 minutes Max 48 units (12 hours) per day Cannot exceed 24 hours w/ other waiver combo Service not paid while in hospital or Nursing Home or Assisted Living Facility Cannot be provided same time as Personal Care Services or Enhanced Care Service	S5135UD	R68.89
Financial Management Services	1 unit equals 1 month	T2040U2	R68.89
Home Telehealth	1 unit equals 1 day	S0317	R68.89
Home Telehealth – Install	1 unit equals 1 installation. Maximum of 2 installations per calendar year.	S0315	R68.89
Medication Reminder	1 unit equals 1 month Excludes adult care homes	S5185	R68.89

Frail Elderly Program (continued)

Benefit Description	Limits	HCPC	DX
Nursing Evaluation Visit	1 unit equals 1 face to face visit Provided by Level II Attendant Care RN or LPN.	T1001	R68.89
Personal Emergency Response System - Install	1 unit equals 1 installation. Maximum of 2 installations per calendar year.	S5160	R68.89
Personal Emergency Response System - Rental	1 unit equals 1 month	S5161	R68.89
Enhanced Care Service	1 unit equals a minimum of 6 hours Only 1 unit in 24 hour period Not to exceed 24 hours w/other waiver combo	T2025	R68.89
Wellness Monitoring	1 unit equals 1 face-to-face visit. Limited to 1 face-to-face visit every 55 days, or less frequently.	S5190	R68.89
Money Follows the Person – Transition Coordination Services	1 unit equals 15 minutes Max 192 units per lifetime	H2015U3	R68.89
Money Follows the Person – Transition Funds	Max $2500	H2016U3	R68.89
Money Follows the Person – All Above Waiver Services	Same Limits as Listed Above Apply for all Services	Same HCPC as Listed Above for Services	R68.89
*** Oral Health Services**	999 units per fee schedule	See Chapter 9 for the applicable dental procedure codes	R68.89

Services with (*) can only be accessed if a crisis exception is approved by KDADS.

Physical Disability Program

Benefit Description	Limits	HCPC	DX
Assistive Services	1 unit equals 1 purchase. Maxiumum $7500 lifetime.	S5165	R68.89
Financial Management Services	1 unit equals 1 month.	T2040U2	R68.89
Home Delivered Meals	1 unit equals 1 meal Max 2 meals per day	S5170	R68.89
Medication Reminder Call	1 unit equals 1 month	S5185	na
Medication Reminder Dispenser	1 unit equals 1 month	T1505U6	na
Medication Reminder – Install	1 unit equals install Max 1 per year	T1505	na

Physical Disability Program (continued)

Benefit Description	Limits	HCPC	DX
Personal Emergency Response System – Install	1 unit equals install Max 2 per year	S5160	na
Personal Emergency Response System – Rental	1 unit equal 1 month	S5161	na
Personal Care Services – Agency Directed	1 unit equals 15 minutes	S5125U9	R68.89
Personal Care Services – Self Directed	1 unit equals 15 minutes	S5125U6	na
Enhanced Care Service	1 unit equals a minimum of 6 hours. Only 1 unit in 24 hour period. Not to exceed 24 hours with other waiver combo.	T2025	na
Money Follows the Person – Transition Coordination Services	1 unit equals 15 minutes Max 192 units per lifetime	H2015U3	R68.89
Money Follows the Person – Transition Funds	Max $2500	H2016U3	R68.89
Money Follows the Person – All Above Waiver Services	Same Limits as Listed Above Apply for all Services	Same HCPC as Listed Above for Services	R68.89

Technology Assisted Program

Benefit Description	Limits	HCPC	DX
Assistive Services (Home Mods)	Max $7,500 lifetime across HCBS programs	S5165	R68.89
Financial Management Services	1 unit equals 1 month	T2040U2	R68.89
Health Maintenance Monitoring	1 unit equals 1 visit 1 unit every 3 months Service cannot be provided or overlap with: T1002, T1000, T1005	T1001	R68.89
Intermittent Intensive Medical Care	4 hours per day Not to exceed 14 days per month Cannot be provided or overlap with: T1001, T1000, T1005	T1002	R68.89
Personal Care Services – Agency Directed	Limited to 372 hours or 1488 units per month. 1 unit equals 15 minutes.	T1004	R68.89
Personal Care Services – Self- Directed	Limited to 372 hours or 1488 units per month. 1 unit equals 15 minutes.	T1019	R68.89

Benefit Description	Limits	HCPC	DX
Medical Respite	Limited to 168 hours or 672 units per calendar year. T1005 cannot be billed on the same day as T1000.	T1005	R68.89
Specialized Medical Care	Limited to 252 hours or 1008 units per month. 1 unit equals 15 minutes. T1000 cannot be bille on the same day as T1005.	T1000	R68.89

Traumatic Brain Injury Program

Benefit Description	Limits	HCPC	DX
Assistive Services Home Mods and Assistive Technology	Maximum $7500 lifetime across all HCBS programs. 1 unit equals 1 purchase.	S5165	na
Behavior Therapy	1 unit equals 15 minutes 3120 units per calendar year – all therapies combined	H0004	na
Cognitive Rehabilitation	1 unit equal 15 minutes 3120 per calendar year – all therapies combined	G0515	na
Financial Management Services	1 unit equals 1 month	T2040U2	R68.89
Home Delivered Meals	1 unit equals 1 meal. Maximum of 2 meals per day. Not to exceed 14 days per month Cannot be provided or overlap with: T1001, T1000, T1005	S5170	R68.89
Medication Reminder Call	1 unit equals 1 month	S5185	na
Medication Reminder Dispenser	1 unit equals 1 calendar month.	T1505UB	na
Medication Reminder Install	1 unit equals install 1 per calendar year	T1505	na
Occupational Therapy	1 unit equals 15 minutes 3120 units per calendar year – all therapies combined	G0152	na
Personal Emergency Response System – Install	1 unit equals install Max 2 per year	S5160	na
Personal Emergency Response System – Rental	1 unit equals 1 month	S5161	na
Personal Care Services – Agency Directed	Maximum of 12 hours per 24-hour time period. 1 unit equals 15 minutes.	S5125U9	na
Personal Care Services – Self-Directed	Maximum of 12 hours per 24-hour time period. 1 unit equals 15 minutes.	S5125UB	na

Traumatic Brain Injury Program (continued)

Benefit Description	Limits	HCPC	DX
Physical Therapy	1 unit equals 15 minutes 3120 units per calendar year – all therapies combined	G0151	na
Enhanced Care Services	1 unit equals a minimum of 6 hours Max 1 unit per 24 hour time period	T2025	na
Speech/Language Therapy	1 unit equals 15 minutes 3120 units per calendar year – all therapies combined	G0153	na
Transitional Living Skills	1 unit equals 15 minutes. May be provided up to 7 days per week. Maximum of 16, 15-minute units (4 hours) per day. Maximum of 3120, 15-minute units per year.	H2014	na
Money Follows the Person – Transition Coordination Services	1 unit equals 15 minutes Max 192 units per lifetime	H2015U3	R68.89
Money Follows the Person – Transition Funds	Max $2500	H2016U3	R68.89
Money Follows the Person – All Above Waiver Services	Money Follows the Person – All Above Waiver Services	H201 Same HCPC as Listed Above for all Services 6U3	R68.89

Serious Emotional Disturbance Program

Benefit Description	Limits	HCPC	DX
Attendant Care	1 unit equals 15 minutes	T1019HK	na
Independent Living/Skills Building	1 unit equals 1 hour	T1019HK	na
Parent Support & Training – Individual	1 unit equals 15 minutes	S5110	na
Parent Support & Training – Group	1 unit equals 15 minutes	S5110TJ	na
Professional Resource Family Care	Per Day	S9485	na
Short Term Respite Care	1 unit equals 15 minutes	S5150	na
Wraparound Facilitation	1 unit equals 15 minutes	H2021	na

Intellectual/Developmental Disability Program

Benefit Description	Limits	HCPC	DX
Residential Supports	1 unit equals 1 day. Service not paid while in hospital, Nursing Home or ICF-IDD.	T2016	na
Day Supports	1 unit equals 15 minutes Max 32 units per 24 hrs Max 100 units per week (7 days) Max 460 units per month Service not paid while in hospital, Nursing Home or ICF-IDD.	T2021	na
Supportive Home Care	1 unit equals 15 minutes. Service not paid while in hospital, Nursing Home or ICF-IDD.	S5125	na
Overnight Respite	1 unit equals 1 day Max 60 days/beneficiary/calendar year	H0045	na
Personal Care Services	1 unit equals 15 minutes. Maximum of 12 hours per 24 hours. Combination of Personal Care Services, Enhanced Care Services, and other HCBS program services shall not exceed 24 hours within a 24 hour period.	T1019	na
Supported Employment	1 unit equals 15 minutes. Service not paid while in hospital, Nursing Home or ICF-IDD.	H2023	na
Enhanced Care Service	1 unit equals 1 day. Minimum of 6 hours. Service not paid while in hospital, Nursing Home or ICF-IDD	T2025	na
Specialized Medical Care (RN)	1 unit equals 15 minutes. Maximum of an average of 12 hours per day or 372 hours (1488 units) per month. Service not paid while in hospital, Nursing Home or ICF-IDD.	T1000 TD	na
Specialized Medical Care (LPN)	1 unit equals 15 minutes. Maximum of an average of 12 hours per day or 372 hours (1488 units) per month. Service not paid while in hospital, Nursing Home or ICF-IDD.	T1000	na
Medical Alert Rental	One unit equals one month	S5161	na
Financial Management Services	1 unit equals 1 month	T2040 U2	R68.89
Wellness Monitoring	1 unit equals 1 visit. Maximum of 1 visit by an RN, per 60 days	S5190	na
Assistive Services	1 unit equals 1 service	S5165	na
Money Follows the Person – All Above Waiver Services	1 unit equals 15 minutes Max 192 units per lifetime	H2015U3	R68.89

Benefit Description	Limits	HCPC	DX
Money Follows the Person – Transition Coordination Services	Max $2500	H2016U3	R68.89
Money Follows the Person – Transition Funds	Same Limits as Listed Above – Apply for all Services	Same HCPC as Listed Above for Services	R68.89

Targeted Case Management Services are also covered to support members with Intellectual/Developmental Disability service needs:

Benefit Description	Limits	HCPC	DX
Targeted Case Management	1 unit equals 15 minutes Maximum 240 units/year	T1017	na

An additional Value Added Benefit is provided to members in the Intellectual/Developmental Disability Program who are Self-Directing or are receiving Supported Home Care:

Benefit Description	Limits	HCPC	DX
Value Added Respite	1 unit equals 15 minutes Maximum 160 units/year (40 hours/year)	S5150	na

Access to the additional respite service can be coordinated through the member's United Care Coordinator.

Providers interested in providing this service will need a different contract payment appendix. Please contact your Provider Advocate if you would like to be a provider for this additional respite service so we can coordinate the update to your contract.

Work Opportunities Reward Kansans (WORK)

The following services are covered for members eligible for the WORK program:

Benefit Description	Limits	HCPC	DX
WORK - Independent Living Counseling	1 unit equals 15 minutes 480 unit max/year	T1016	na
WORK - Assistive Services	1 unit equals 1 service $7,500 annual limit	S5165	na

13.7 KanCare Claim Filing Information for Nursing Facilities

Nursing facilities should use the UB-04 claim form or accepted electronic equivalent when requesting payment for **Nursing Facility services.** Claims may be received through your electronic data interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 96385. Paper claims may be submitted to the claims address indicated below. Providers may also bill through the KanCare Front End Billing solution as defined in KMAP General Bulletin 12115.

ICF-IID providers should follow the billing guidelines and procedures as outlined in the state provider manual with the exception of dental service billing. Dental providers will contract with UnitedHealthcare Community Plan's dental sub-contractor and will bill the Skygen USA (formerly called Scion) directly as indicated in the dental chapter of this manual.

The Care Coordinator who is assigned to the facility will validate those members eligible for Long Term Care (custodial) services with facility staff upon member enrollment and confirm the ongoing MCO census at minimum quarterly. KanCare Long Term Care (custodial) members residing in nursing facilities will NOT require prior authorization of the custodial stay. Facilities do not need to submit any prior authorization information when claims are submitted.

Note: Services or supplies that are included in the per diem rate (e.g. oxygen) do NOT require separate prior authorization.

Notification of Nursing Facility Admission/Discharge MS-2126

The completion of the MS-2126 (Notification of Nursing Facility Admission/Discharge) must be completed by the provider. The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. Submission of the MS-2126 is not required as a prerequisite for a hospital "reserve day" (Section IV of the MS-2126). However, the MS-2126 must be retained in the beneficiary's file for documentation. Completion of the MS-2126 is not required for payment of a therapeutic reserve day.

Revenue Codes:

- 101 Custodial Care
- 120 Skilled Nursing (Revenue Code 120 should only be utilized when billed for a Medicare short-term stay)
- 180 NF for MH (inpatient psychiatric hospital stay – 21-day limit per psychiatric hospital stay admission)
- 183 NF for MH home therapeutic reserve days (21 days per calendar year)
- 183 NF home therapeutic reserve days (18 days per calendar year)
- 185 NF hospital reserve days (10 day limit per hospital admission)
- 189 Non-covered days
- Revenue Code 0771 and HCPC Code G0008
- Flu Vaccine – The influenza (flu) virus vaccine is usually administered once a year in the fall or winter. Medicare Part B covers the influenza virus vaccine and its administration. Medicaid beneficiaries not covered by Medicare Part B will require a physician's order. The flu vaccine and its administration shall be billed by the beneficiary's attending physician.

Nursing Facility Bill Types:

Enter the three-digit number specific to the type of claim

1st digit:

2 – Skilled nursing

6 – Intermediate care

2nd digit:

If the 1st digit is a 2, the second digit is:

1 – Inpatient

If the 1st digit is a 6, the second digit is:

5 – Level 1

6 – Level 2

3rd digit:

0 – Nonpayment/zero claim

1 – Admit through discharge claim

2 – Interim – first claim

3 – Interim – continuing claim

4 – Interim – last claim through date to discharge date

7 – Replacement of a prior claim

8 – Void/Cancel of a prior claim

Nursing Facilities Services:

The services outlined below are included in the nursing facility per diem and cannot be billed or paid separately. For a detailed list of services and supplies included in the nursing facility per diem, please reference the state KMAP Nursing/Intermediate Care Facility Manual.

- Licensed nursing supervision 24 hours per day, seven days a week
- Specialized rehabilitation services
- Routine medical equipment and supplies including all durable medical equipment, including oxygen and all oxygen related supplies
- Physical, speech, occupational, respiratory and all other therapies
- Transportation
- Over the counter medications provided on an as-needed or PRN basis are part of the per diem

- Dietitian services
- Assistance with daily living skills
- Miscellaneous services and supplies considered routine to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the Person-Centered Service Plan.

Admission, Transfer, and Discharge Rights of Residents in Adult Care Homes

Each licensee, administrator, or operator shall comply with state regulation KAR 26-39-102 in the admission, transfer and discharge rights of residents in adult care homes.

Patient Liability

The state communicates each member's applicable patient liability to UnitedHealthcare Community Plan via the enrollment file and the applicable patient liability amount is deducted from the nursing facility claim payment amount.

Patient liability is the amount of a member's income, as determined by DCF, to be collected each month.

Nursing facilities are expected to collect patient liability amounts from the members and may utilize appropriate legal actions to collect these amounts.

If a member fails to pay his or her patient liability, the nursing facility may refuse to continue to provide services in compliance with KAR 26-39-102. The nursing facility must demonstrate that it has made a good faith effort to collect payment and must notify the member's care coordinator prior to discharge. The member should receive appropriate notice and education regarding the consequences of non-payment of patient liability, including potential disenrollment from the KanCare program.

NPI Filing Requirements

A National Provider Identifier (NPI) is required for all Kansas medical providers. All provider identifiers must be valid NPI numbers.

This includes billing, servicing, rendering, attending, operating, referring and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

Paper Claim Submission Address

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

Initial paper claims and corrected paper claims should both be submitted to this address.

Reconsideration Requests

If you have questions relating to claims payments please contact Provider Services at 877-542-9235. A Provider Services Representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, requests can be forwarded to:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

Additional information on the provider reconsideration process can be found in Chapter 15 of the Provider Administrative Guides located at **UHCprovider.com/kscommunityplan**.

Mailing Appeals

If you have filed a reconsideration request and are not satisfied with the outcome, you may file an appeal to the following address:

UnitedHealthcare Community Plan
Attn: Grievance and Appeals Dept.
P.O. Box 31364
Salt Lake City, UT 84131-0364

Additional information on the provider reconsideration process can be found in Chapter 15 of the Provider Administrative Guides located at **UHCprovider.com/kscommunityplan**.

From and Through Service Dates Bill Both Header and Detail

Box 6 of the UB "Statement covers period" from and through dates must equal the room and board units being billed in Box 46. For example, if billing for 30 units in April, the Statement Covers Period must be April 1 to April 30. For those uploading via a billing software, the statement covers from and through date maps to the EDI837I Loop 2300 DTP*434*RD8 segment which covers a date range.

Box 45 must be completed if two or more line items are being billed on the claim form.

Retro-Eligible Process for Filing Claims

Applies to both behavioral health and medical services. **Do not submit medical records with claims submissions.**

To ensure timely payments upon claims submission, please note:

Paper Claim

- Indicate "Retro-Eligible" in Form Locator 80 NTE/REMARKS (UB) or indicate at the top of the claim form.
- Attach cover letter stating member is retro-eligible.
- When documentation is required for retro-eligible authorization review, the Medical Review Unit will request that documentation from the provider.

Electronic Claim

- Indicate "Retro-Eligible" in the NTE field in electronic file (Loop 2300 for UB).
- When documentation is required for a retro-eligible authorization review, the Medical Review Unit will require that documentation from the provider via fax.

Corrected Claims

Paper Corrected Claim Resubmission Process

- Corrected claim should be mailed to:

  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402

- Write "CORRECTED" on the claim.
- Update the 3rd digit of the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- Providers may also update the third digit of the bill type to an 8 to void the claim.
- If billing with a 217 or 218 Type of Bill providers will need the original claim number. We can provide the claim number from the EDI tab in the claim screen. When billing a paper claim, the previous claim number should be entered in Box 57.

Electronic Corrected Claim Resubmission Process
UB Claims:

- Providers may submit a corrected claim electronically through their claim clearinghouse.
- Update the 3rd digit in the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- Providers may also update the third digit of the bill type to an 8 to void the claim.
- If billing with a 217 or 218 Type of Bill providers will need the original claim number. We can provide the claim number from the EDI tab in the claim screen. Providers should consult with their electronic claim vendor for the appropriate field to enter the original claim number for an electronic submission.

Electronic Payments & Statements (EPS)

EPS is our solution for electronic remittance advice (ERA) and electronic funds transfer (EFT). EPS allows you to access your explanation of benefits (EOBs) online and receive direct deposit of claim payments into your checking or savings account."

How EPS Works:

- Claim payments are deposited directly into your designated bank account, up to five to seven days faster than the paper payment process

- You have the option to split routing of payments and remittance advices by National Provider Identifier (NPI) number and/or payer.

- You receive email notification of payments.
  - Multiple users can receive notifications.
  - Users can be assigned different access levels.
- You can view your information online, or receive 835 ERA files from your clearinghouse/vendor.
  - View remittance advices for the last 30, 60, or 90 days or use advanced search options.
  - Save PDF remittance advice files to your computer rather than printing and filing copies. You can print individually or in bulk.

Easy Enrollment

- You can enroll in EPS online, or print and send in your completed enrollment form. You will need:
  1. Bank account information for direct deposit
  2. Either a voided check or a bank letter to verify bank account information
  3. A copy of your organization's W-9 form
- Use the following link to learn more, or call 866-842-3278, option 5.

Electronic Payments & Statements (EPS) Additional Information and Enrollment

13.8 KanCare Claim Filing Information for HCBS Providers

HCBS program codes and limits noted on section 13.6 apply to all Home and Community Based Services. Covered services, service definitions, units and benefit limitations are consistent with the Kansas Medical Assistance Program (KMAP) Provider Manuals. Please reference the KMAP manuals for specific service definitions.

HCBS providers should use the CMS 1500 claim form or an accepted electronic equivalent when requesting payment for HCBS services. Claims may be received through your Electronic Data Interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 96385. Paper claims may be submitted to the claims address indicated below. Providers may submit claims directly through our secure provider portal at **UHCprovider.com**, and they may also submit claims through the KanCare Front End Billing solution as defined in KMAP General Bulletin 12115.

Documentation

UnitedHealthcare Community Plan follows the service documentation guidelines as defined in the Kansas Medical Assistance Provider (KMAP) Manuals, including KMAP guidelines for electronic documentation and electronic signatures as defined in the KMAP General Billing Manual.

Client Obligation

The state will communicate each member's client obligation, as applicable, to UnitedHealthcare Community Plan via the member enrollment file we receive from the state. Providers who have been assigned the client obligation should not reduce the billed amount on the claim by the client obligation amount because it will be deducted as claims are processed.

UnitedHealthcare Community Plan will make every effort to assign the client obligation, as applicable, to the provider that was historically assigned the client obligation by the state. The client obligation will typically be assigned to a single provider (if a single provider's services will offset the client obligation amount). In addition, we will make every effort to assign the client obligation to a single service, when possible, if the total services provided each month for that service are sufficient to offset the monthly client obligation amount. In the absence of state direction, we will assign client obligation to the provider that has the largest cost of services for the month.

On a monthly basis, a notification letter will be mailed to each member and a report will be sent to each provider that details all of the members that are assigned client obligation for the month. We will communicate mid-month changes relative to client obligation amounts within five days of receipt of information from the state. Both members and providers will receive a letter mid-month with the client obligation changes.

Date Span Billing

Providers may bill for date spans as they have in the past.

- Providers are currently going to be able to bill non-consecutive days with date span billing.
- Providers cannot overlap billed date spans, otherwise the claims may experience possible duplication edits and/or other claim errors.

Providers must file claims with date spans that fall within one authorization. Providers may not bill for date spans across months.

State Approved Billing Guidelines when KanCare Members have Other Coverage

If the member has Third Party Liability (TPL), or insurance coverage, other than KanCare:

Effective with the dates of service on an after 7/1/16, the following codes will be considered noncovered regardless of health insurance carrier. If the service code being billed is on this list, a remittance advice from the primary carrier is not required. Providers may bill these services directly to UnitedHealthcare Community Plan either electronically or on paper claims.

97532, 99368, 99408, G0151, G0152, G0153, H0001, H0002, H0004, H0005, H0017, H0018, H0036, H0038, H0045, H0049, H0050, H2010, H2011, H2012, H2014, H2015, H2017, H2019, H2021, H2023, H2032, S0315, S0316, S0317, S5101, S5102, S5110, S5125, S5126, S5130, S5135, S5150, S5160, S5161, S5165, S5170, S5185, S5190, S9128, S9129, S9131, S9446, S9482, T1000, T1002, T1004, T1005, T1016, T1017, T1019, T1023, T1027, T1505, T2002, T2003, T2011, T2016, T2020, T2021, T2023, T2024, T2025, T2028, T2029, T2038, T2039, T2040, T2046, T4521, T4526, T4530

If the code billed is not on this list and the member has TPL, or insurance coverage, other than KanCare:

The other insurance is the primary carrier. Providers should bill the primary carrier and, upon payment or denial, submit the claim to UnitedHealthcare Community Plan.

- The claim may be submitted to UnitedHealthcare Community Plan through an EDI transaction or submitted on paper with a paper copy of the primary carrier's EOB.
- The claim may be submitted electronically through the KMAP portal. Providers must follow the KMAP billing guidelines when entering TPL information as defined in the KMAP Professional Billing Guide.

NPI Filing Requirements

A National Provider Identifier (NPI) is required for all Kansas medical providers, and all provider identifiers billed on claims must be valid NPI numbers.

This includes billing, servicing, rendering, attending, operating, referring, and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

We require providers to obtain an NPI only in those instances in which an NPI is required by the State for the services offered by the provider. If an NPI number is required by the state, we require a group NPI number to be filed on a claim. If the State has not required a provider NPI, we treat those providers as atypical providers for whom an NPI is not required.

If you are an atypical provider, a valid Kansas KMAP ID must be used. Providers who are not already enrolled with KMAP, should contact their UnitedHealthcare HCBS Provider Advocate for assistance in obtaining a KMAP ID for billing purposes.

Corrected Claims

To file a corrected claim Electronically through Link: claimsLink Application:

- Follow steps outlined in the Claim Reconsideration/Corrected Claims Quick Reference.
- Choose Reason Request
- Follow the next steps as prompted
- Use the Comments field to clearly explain in detail what you are expecting with the corrected claim.
- Attach a corrected CMS 1500 to the request. Write "CORRECTED" on the face of the claim. Add Resubmission code "7" and the United original claim number in Box 22.

To file a corrected claim **electronically** through the KMAP Front End Billing option:

- Create a new day claim through the KMAP Front End Billing option.
- Enter the United Original Claim Number (from the remittance advice) in the Timely Filing Override ICN Field.
- Provide all information that is correct for the claim and submit it as a new claim.
- The claim will be identified as a corrected claim due to the presence of the UHN Original Claim Number.

- The electronic corrected claim process is only available when the original claim was filed through the KMAP front end billing option. Claims originally filed through Authenticare or through the UnitedHealthcare portal must be corrected through the paper corrected claims process.

To file a corrected claim via **paper**:

- Providers may also file corrected claims via paper by sending corrected claims to:

  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402

- Write "CORRECTED" on the face of the claim. Add Resubmission code "7" and the United original claim number in Box 22.

To correct an **EVV/AuthentiCare claim:**

- If the EVV claim was already released, providers should follow one of the above corrected claim processes.

Paper Claim Submission Address

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

Claims Reconsideration Requests

Providers have 120 calendar days, plus 3 calendar days (if the notice is mailed) from the remittance date to submit claim reconsiderations.

Requests can be submitted through various means:

- **Phone:** 877-542-9235
- **Electronically:** UnitedHealthcare portal (UHCprovider.com) using the Link: claimsLink Application. Follow steps outlined in the Link: claimsLink Claim Reconsideration Quick Reference Guide.
- **Paper:** Use the Claim Reconsideration Request Form and sending the request to
  UnitedHealthcare Community Plan
  PO Box 31350
  Salt Lake City, UT 84131-0350

Mailing Appeals

If you have filed a reconsideration request and are not satisfied with the outcome, you may file an appeal to the following address:

UnitedHealthcare Community Plan
Attention: Formal Grievances and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Additional information on the provider appeal process can be found in Chapter 15 of the Provider Administrative Guides located at UHCprovider.com/kscommunityplan.

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How EPS Works:

- Claim payments are deposited directly into your designated bank account, up to five to seven days faster than the paper payment process.
  - You have the option to split routing of payments and remittance advices by National Provider Identifier (NPI) number and/or payer.
- You receive email notification of payments.
  - Multiple users can receive notifications.
  - Users can be assigned different access levels.
- You can view your information online, or receive 835 ERA files from your clearinghouse/vendor.
  - View remittance advices for the last 30, 60, or 90 days or use advanced search options.
  - Save PDF remittance advice files to your computer rather than printing and filing copies. You can print individually or in bulk.

Electronic Payments & Statements (EPS) EFT Enrollment is available online and on paper. The online enrollment process is accessible at **www.optumhealthfinancial.com**. The online form for paper enrollment can also be accessed at **www.optumhealthfinancial.com**.

Please have the following information available to complete your enrollment:

- Organization Name and mailing information
- Tax Identification Number (TIN) and National Provider Identifier(s) (NPI)
- Contact information for your designated EPS contacts
- Banking information for direct deposit — at the TIN level and NPI level is also available

If you need help enrolling in EPS or using any of its features, please call us at **877-620-6194**. Choose "option 1" for enrollment and "option 2" for access questions.

Electronic Payments & Statements (EPS) Additional Information and Enrollment

13.9 Electronic Visit Verification

Electronic Visit Verification (EVV) Requirements

HCBS providers must use AuthentiCare for EVV for the following services.

AuthentiCare should not be used in assisted living, residential health care, home plus or boarding home care settings (including Attendant Care, Wellness Monitoring and Adult Day Care) for HCBS services.

Adult Day Care providers should use AuthentiCare only when services are provided in a free standing licensed adult day are setting.

Providers are encouraged to access the KS AuthentiCare User Manual for additional information regarding use of the AuthentiCare system.

Frail Elderly Program

Service

- Adult Day Care – Half Day
- Personal Care Services – Level I
- Personal Care Services – Level II
- Personal Care Services – Self-Directed
- Comprehensive Support – Provider Directed
- Comprehensive Support – Self Directed
- Financial Management Services (FMS)
- Nurse Evaluation Visits
- Personal Emergency Response – Install
- Personal Emergency Response – Monthly Rental
- Enhanced Care Services
- Wellness Monitoring

Physical Disability Program and Traumatic Brain Injury Program

Service

- Financial Management Services (FMS)
- Medication Reminder Dispenser Installation
- Medication Reminder Dispenser (monthly rental)
- Personal Emergency Response System Installation
- Personal Emergency Response (monthly rental)
- Personal Care Services – Agency

- Personal Care Services – Self-Directed
- Enhanced Care Services

Technology Assisted Program:

Service

- Financial Management Services (FMS)
- Personal Care Services – Self-Directed

Tramatic Brain Injury Program

Service

- Financial Management Services (FMS)
- Medication Reminder Dispenser Installation
- Medication Reminder Dispenser (monthly rental)
- Personal Emergency Response System Installation
- Personal Emergency Response (monthly rental)
- Personal Care Services – Agency
- Personal Care Services – Self-Directed
- Enhanced Care Services

Intellectual/Developmental Disability Program

Service

- Personal Care Services
- Enhanced Care Services
- Overnight Respite
- LPN Specialized Medical Care
- RN Specialized Medical Care
- Supportive Home Care
- Medical Alert Rental
- Financial Management Services

Authenticare Requirements

HCBS providers utilizing EVV through AuthentiCare are responsible for monitoring and immediately addressing service gaps including back-up staffing.

Providers with more than one KMAP ID will be asked to choose only one for future billing and authorizations.

New providers can obtain an AuthentiCare user account, via **authenticare.com/kansas** and click on "contact us".

Notes in KS AuthentiCare:

- Providers are expected to use the "notes" field in the KS AuthentiCare web application every time adjustments are made (time in/out or activity codes, for example). At a minimum, the following information needs to be included in notes:
  - The person requesting the adjustment
  - Specifically what is being adjusted (clock in at 10:35 a.m. added, activity codes for bathing added and toileting removed, etc.)
  - Reason for the adjustment (started shopping outside of home, forgot to clock in/out, etc.)
  - If the adjustment was confirmed with the beneficiary
- Provider and member information will be populated into Authenticare. The provider must add:
  - Provider email address for late/missed visit alerts
  - Client's telephone number
  - Initial worker data will be loaded by Authenticare if the provider returns a required worker information excel spreadsheet
- After implementation, the provider must maintain all worker information.

13.10 Money Follows the Person

Money Follows the Person (MFP) services are available to qualified beneficiaries. These services are specific to beneficiaries transitioning into the community from designated institutional settings. Providers are encouraged to refer to the Kansas Medical Assistance Program (KMAP) Money Follows the Person Provider Manual for criteria and additional specific information.

The Money Follows the Person (MFP) demonstration program not only allows residents to receive Home and Community Based Services (HCBS) in the community but also enhanced services which allow for payment of utility deposits and reasonable expenses to re-establish a residence. MFP enhanced services will make it possible for the resident to return to the community. The four HCBS program populations that will be served by this grant are Frail Elderly (FE), Physical Disability (PD) Traumatic Brain Injury (TBI) and Intellectual/Developmental Disability (I/DD).

All MFP services, with the exception of oral health services and community bridge building, require prior authorization (PA) through the Person-Centered Service Plan (PCSP) process.

Services available under Money Follows the Person

In addition to all services available under the corresponding HCBS program, individuals on the MFP program will also receive Transition Service Coordination and Transitions Funds (up to $2500.)

Housing Options for MFP Participants

- Home owned or leased by the participant or participant's relative

- Leased apartment or home, lockable egress, includes living, sleeping, and cooking areas
- Community-based residence for no more than four unrelated individuals (I/DD only)
- Assisted living facilities for the FE and PD populations only

13.11 Financial Management Services (FMS)

Financial Management Services (FMS) is provided for Frail Elderly, Physical Disability, Technology Assisted, Traumatic Brain Injury and Intellectual/Developmental Disability Program beneficiaries.

The FMS provider must be listed on the Person-Centered Service Plan and the administrative functions of the FMS provider are reimbursed as an HCBS program service.

Additional details may be found in the Kansas Medical Assistance Program (KMAP) HCBS FMS Provider Manual. We follow the service description, billing guidelines, service and provider requirements and other protocols as outlined in the KMAP FMS Manual.

13.12 Care Coordination

Care Coordination for Nursing Facility Residents

Care Coordinators are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care within 30 days of member assignment and with significant changes, annual reassessments
- Assisting with transition management following inpatient admissions
- Facilitating integration with Optum Behavioral Health as needed to support the member and family

Care Coordination for HCBS Program Members

Care Coordinators are responsible for:

- Creating a Person-Centered Service Plan that includes a comprehensive assessment of the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care/service plan development within seven days of member assignment, contacts quarterly and with significant changes, annual reassessments
- Assisting with transition management following inpatient admissions
- Supporting and educating on chronic condition management

- Facilitating community resource linkages
- Submitting the authorization for HCBS services. The provider receives written confirmation of the authorization and services to be delivered
- Contacting HCBS members quarterly at minimum and with significant changes in condition; face-to-face reviews occur every six months at minimum

Additional Information Regarding Care Coordination for the Intellectual/Developmental Disability Program

UnitedHealthcare Community Plan Care Coordinators will act as a resource to the Targeted Case Managers and the member/support team and will complete internal assessments and drive the Person-Centered Service Plan.

One of the key tasks a Care Coordinator can assist with is helping the member and/or the Targeted Case Manager navigate the managed care system (for example: obtaining DME and assisted services, coordinating complex medical or behavioral health care needs, and making sure that covered benefits are acquired appropriately).

Targeted Case Managers will continue to complete tasks associated with the four areas CMS has outlined as Targeted Case Management:

- Assessment
- Development of a Person-Centered Service Plan (PCSP)
- Referral and related activities
- Monitoring and following up

UnitedHealthcare Community Plan Care Coordinators will collaborate with our members and their Targeted Case Managers to:

- Participate in Person-Centered support planning either in person at the meeting (if invited) or providing resources before and after meeting
- Conduct member assessments and visits in the member's home or intermediate care facility setting
- Develop a Person-Centered Service Plan for each member
- Facilitate access to needed services/supports for members
- Coordinate transitions of care between institutions, facilities, different HCBS programs, and/or service providers as needed