Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS

Financial Management Services

Updated 04.2014

PART II
HCBS FMS FEE-FOR-SERVICE PROVIDER MANUAL

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

INTRODUCTION TO THE HCBS FMS PROGRAM Updated 10/13

The Home and Community Based Services (HCBS) waiver 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 waiver services require prior authorization through the plan of care (POC) process.

Money Follows the Person Program
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. Refer to the *Money Follows the Person Fee-for-Service Provider Manual* for criteria and additional information.

Enrollment
All HCBS FE providers must enroll and receive a provider number for HCBS services. Contact the fiscal agent to enroll. Provider enrollment information is on the Provider page of the KMAP website.

Manuals
The provider manual is divided into two parts. This provider-specific section of the manual (Part II) is designed to provide information and instructions specific to providers of HCBS FMS waiver program services. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection provides instructions on claim submission.

The **Benefits and Limitations** subsection outlines services included for HCBS FMS beneficiaries and limitations on these services. It also includes qualifications for HCBS FMS providers, documentation requirements for reimbursement, and expected service outcomes.

Miscellaneous Documentation
With the transition to an Electronic Verification and Monitoring (EV&M) system through KS AuthentiCare, recoupments are no longer identified solely based on the lack of meeting documentation requirements for dates of service from January 1 to April 30, 2012.

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 the note:

- 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

INTRODUCTION TO THE HCBS FMS PROGRAM Created 06/11

HIPAA Compliance

As a participant in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required during its review and investigation. The provider is required to provide access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider must not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. HCBS FMS BILLING INSTRUCTIONS Updated 10/13

All claims for FMS must be submitted through the EV&M system, KS AuthentiCare, web application.

Introduction to the CMS-1500 Claim Form

Providers must use the CMS-1500 when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original red claim form and completed as indicated. Any CMS-1500 claim not submitted on a red claim form will be returned to the provider.

An example of the CMS-1500 and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms) heading.

Any of the following billing errors may cause a CMS-1500 claim to deny or be sent back to the provider:

- The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed. Claim information must be submitted in the correct fields as instructed.
- Staples on the claim form.
- A CMS-1500 claim form carbon copy.

The fiscal agent does not furnish the CMS-1500 claim form to providers.

Submission of Claim

Send completed first page of each claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571

7010. HCBS FMS SPECIFIC BILLING INSTRUCTIONS Created 06/11

Enter diagnosis code 780.99 in field 21 on the CMS-1500.

Enter the authorized procedure code with the modifier (T2040 U2) in field 24D of the CMS-1500.

One unit equals one month.

Client Obligation
If a case manager has assigned a client obligation to a particular provider and informed this provider that they are to collect this portion of the cost of service from the client, the provider will not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Overlapping Dates of Service
The dates of service on the claim must match the dates approved on the POC and cannot overlap.

Example
An electronic POC has two detail line items: the first line ends on the 15th of the month and the second line begins on the 16th with an increase of units.
A claim with a line item for services dated the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC for one line on a claim.
For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month will be accepted by the system and not deny because of a conflict in the dates of service.

Services for multiple months should be separated out and each month submitted on a separate claim.

Same Day Service
For certain situations, HCBS services approved on a POC and provided the same day a beneficiary is hospitalized or in a nursing facility may be allowed. Situations are limited to:

- HCBS services provided the date of admission, if provided PRIOR to beneficiary being admitted
- HCBS services provided the date of discharge, if provided FOLLOWING the beneficiary's discharge
- HCBS case management provided 30 days prior to discharge
- Emergency Response Services

8400. BENEFITS AND LIMITATIONS Created 06/11

FINANCIAL MANAGEMENT SERVICES

Financial Management Services (FMS) is provided for beneficiaries who are aging or disabled and will be provided within the scope of the Agency with Choice (AWC) model. Within the self-directed model and Kansas state law (K.S.A. 39-7,100), beneficiaries have the right to "make decisions about, direct the provisions of and control the attendant care services received by such individuals including, but not limited to selecting, training, managing, paying and dismissing of a direct support worker." The beneficiary or beneficiary's representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a system of available supports. FMS is included in these supports.

The AWC FMS is the employer-option model Kansas has available to beneficiaries who reside in their own private residence or the private home of a family member and have chosen to self-direct some or all of their services. The beneficiary or his or her representative has the right to choose this employer-option model and the right to choose from qualified available FMS providers. This information must be made available at the time of making the choice to self-direct services and annually thereafter. The FMS provider must be listed on the POC and the administrative functions of the FMS provider are reimbursed as a waiver service.

When a beneficiary or beneficiary's representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

- Choose and direct support services
- Choose and direct the workers who provide the services
- Perform the roles and responsibilities as employer
- Understand the roles and responsibilities of the FMS provider
- Receive initial and ongoing skills training as requested

Once fully informed, the beneficiary or beneficiary's representative must negotiate, review, and sign an FMS Service Agreement developed and made available by the State of Kansas and distributed by the FMS provider. The FMS Service Agreement will identify the "negotiated" role and responsibilities of both the beneficiary and the FMS provider. It will specify the responsibilities of each party.

The self-directing beneficiary or beneficiary's representative has the responsibility to:

- Act as the employer for the direct support workers or designate a representative to manage or help manage the direct support workers
- Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the beneficiary and the FMS provider
- Select the direct support worker(s)
- Refer the direct support workers to the FMS provider for completion of required human resources and payroll documentation
  Note: In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
- Negotiate an Employment Service Agreement with the direct support worker that clearly identifies the responsibilities of all parties
- Provide or arrange for appropriate orientation and training of the direct support worker(s)
- Determine the schedules of the direct support worker(s)

8400. BENEFITS AND LIMITATIONS Updated 04/14

FINANCIAL MANAGEMENT SERVICES

The self-directing beneficiary or beneficiary's representative has the responsibility to: (continued)

- Determine the tasks to be performed by the direct support worker(s) and where and when they are to be performed in accordance with the approved and authorized POC/person-centered support plan (PCSP)/Attendant Care Worksheet (ACW)/Customer Service Worksheet (CSW) and/or others as identified and applicable to each specific waiver
- Manage and supervise the day-to-day HCBS activities of the direct support worker(s)
- Verify the time worked by the direct support worker(s) was delivered according to the POC
- Ensure submission of required direct support worker documents to the FMS provider for processing and payment in accordance with the established FMS, state, and federal requirements ***Note:*** The documentation must reflect actual hours worked in accordance with an approved POC.
- Report work-related injuries incurred by the direct support worker(s) to the FMS provider agency staff
- Develop an emergency worker backup plan in case a substitute direct support worker is ever needed on short notice or as a backup (short-term replacement worker)
- Ensure all appropriate service documentation is recorded as required by the State of Kansas HCBS waiver program policies, procedures, or by the Medicaid Provider Agreement
- Inform the FMS provider of any changes in the status of direct support worker(s), such as a change of address or telephone number, in a timely fashion
- Inform the FMS provider and case manager of the dismissal of a direct support worker within three working days
- Inform the FMS provider and case manager of any changes in the status of the beneficiary or beneficiary's representative, such as the beneficiary's address, telephone number, or hospitalizations, within three working days
- Participate in required quality assurance visits with case managers, state Quality Assurance staff, state quality management specialist (QMS), or other appropriate and authorized reviewers/auditors

The FMS provider has the responsibility to:

- Comply with the provisions of KSA 39-7,100 [Home and community based services program] and KSA 65-6201 [Individuals in need of in-home care; definitions]
- Execute a Kansas Department for Aging and Disability Services (KDADS) ~~of Social and Rehabilitation Services (SRS)/Kansas Department on Aging (KDOA)~~ Provider Agreement with the appropriate state agency
- Execute a Medicaid Provider Agreement with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF)
- Comply with state regulations, KDADS Provider Agreement requirements, Medicaid Provider Agreement requirements, policies, and procedures to provide services to eligible beneficiaries
- Develop and implement procedures, internal controls, and other safeguards that reflect Kansas state law (the guiding principles of self-direction) to ensure the beneficiary or beneficiary's representative, rather than the FMS provider, have the right to choose, direct, and control the services and direct support worker(s) who provide them without excessive restrictions or barriers

FINANCIAL MANAGEMENT SERVICES
The FMS provider has the responsibility to: (continued)

Note: The procedures, internal controls, and other safeguards must be written and must include, at a minimum:

- A mechanism to process the direct support worker's human resource documentation and payroll in a manner that is efficient and supports the beneficiary's or beneficiary's representative's authority to select, recruit, hire, manage, dismiss, and train direct support workers
- Information for the direct support worker that outlines the completion of time keeping process, wages, benefits, pay days, work hours, and the beneficiary's self-direct preferences
- An assurance that the beneficiary or beneficiary's representative, not the FMS provider, determines the terms and conditions of work (when and how the services are provided, such as establishing work schedules, determining work conditions [for example, smoking restrictions in the home, conditions for dismissal] and tasks to be preformed)
- Internal controls to ensure the beneficiary or beneficiary's representative is afforded choice and control over workers without excessive restrictions or barriers
- A process to respond, within a reasonable time frame, to contact from the beneficiary or beneficiary's representative informing the FMS provider of the decision to dismiss a particular direct support worker
- A process for the self-directing beneficiary or beneficiary's representative to pay the direct support worker(s) or for the self-directing beneficiary or beneficiary's representative to delegate the direct support worker(s) payment by direct deposit, first class mailing, or other means through the FMS provider agency staff

- Ensure the self-directing beneficiary or beneficiary's representative and the case manager have the name and contact information of the FMS provider agency staff who can address their issues
- Assume responsibilities in providing the following administrative services:
  - Establish and maintain all required records and documentation, to include a file for each self-directing beneficiary per State of Kansas regulations, policies, and procedures and in accordance with Medicaid provider requirements
    Note: All files must be maintained in a confidential, HIPAA-compliant manner.
  - Obtain authorizations to conduct criminal background checks, child abuse, and adult registry checks in accordance with applicable waiver requirements
  - Verify citizenship and legal status of potential direct support workers
  - Collect and process all required federal, state, and local human resource forms required for employment and the production of payroll
  - Help the self-directing beneficiary or the beneficiary's representative set the correct pay rate for each direct support worker as allowed under the procedures set by the State of Kansas
  - Verify and process time worked by direct support worker(s)
  - Compute, withhold, file, and deposit federal, state, and local employment taxes for the direct support worker(s).
  - Compute and pay workers compensation as contractually and statutorily required

8400. BENEFITS AND LIMITATIONS Created 06/11

FINANCIAL MANAGEMENT SERVICES
The FMS provider has the responsibility to: (continued)

- Approve and pay wages to the direct support worker(s) in compliance with federal and state labor laws
- Perform all end-of-year federal, state, and local wage and tax filing requirements, as applicable (that is, IRS forms W-2 and W-3, state income tax forms and reporting)
- Have policies and procedures in place for reporting fraud and/or abuse, neglect, or exploitation by a direct support worker to the appropriate authority and informing the beneficiary or beneficiary's representative that if the direct support worker continues to work for the beneficiary, they will no longer be able to serve as the FMS provider agency

- Ensure each self-directing beneficiary:
  - Maintains control and oversight of his or her direct support worker
  - Is aware of the benefits/services available to him or her
  - Is aware of his or her requirements and responsibilities to the FMS provider agency
  - Is aware of his or her requirements and responsibilities to the direct support workers, including a signed Employment Service Agreement that specifies the responsibilities of the parties in a language/format that is understandable to the worker
- Ensure each direct support worker hired by the self-directing beneficiary:
  - Is aware of the benefits/services available to him or her
  - Is aware of the employment requirements and job responsibilities of the self-directing beneficiary and FMS provider
- Maintain a listing of direct support workers who are available and desire additional employment
- Develop, implement, and maintain an internal quality assurance program that monitors for:
  - Self-directed beneficiary's satisfaction
  - Direct support worker's satisfaction
  - Correct submission of direct support worker's time worked
  - Correct payroll distribution
- Develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency
- Maintain evidence of certifications, agreements, and affiliations as required by waiver or policy (such as community developmental disability organization [CDDO] affiliation agreements for developmental disabilities services)

Information and Assistance has been incorporated into the definition and requirements of the FMS provider:

- Information and Assistance (I&A) is a service available to provide information, including independent resources, and assistance in the development of options to ensure beneficiaries understand the responsibilities involved with directing their services. Practical skills training is offered to enable self-directing beneficiaries, their families, and/or representatives to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring direct support workers, managing workers, effectively communicating, and problem-solving. The extent of the assistance furnished to the self-directing beneficiary will be determined by the self-directing beneficiary or beneficiary's representative.

8400. BENEFITS AND LIMITATIONS Updated 04/14

FINANCIAL MANAGEMENT SERVICES
Information and Assistance has been incorporated into the definition and requirements of the FMS provider: (continued)

- I&A services may include activities that nominally overlap with the provision of information concerning self-direction provided by a case manager. However, this overlap does not allow the FMS provider to be involved in the development of the individual service plan and/or other planning documents or assessments.
- I&A services may provide assistance to the self-directed beneficiary or beneficiary's representative with:
    - Defining goals, needs, and resources
    - Identifying and accessing services, supports, and resources as they pertain to self-directed activities
    - Learning practical management skills training (such as hiring, managing, and terminating workers; problem solving; conflict resolution)
    - Recognizing and reporting critical events (such as fraudulent activities, abuse)
    - Managing services and supports
- I&A services may provide information to the self-directing beneficiary or beneficiary's representative about:
    - Individual-centered planning
    - Range and scope of beneficiary's choices and options
    - Grievance and appeals processes
    - Risks and responsibilities of self-direction
    - Individual rights
    - Importance of ensuring direct support worker's health and safety during the course of his or her duties to reduce potential injuries and workers compensation insurance claims
      Note: This may include participation in training as directed by the self-directing beneficiary.
    - Reassessment and review schedules
    - Importance of keeping the FMS provider agency and case manager informed with current contact information and planned absences
    - Other subjects pertinent to the beneficiary and/or family in managing and directing services and living independently and safely in the community in the most integrated setting
- The Kansas "Self-Direction Tool Kit" is recommended as a resource for I&A.
- The I&A services a beneficiary chooses to access must be outlined in a service agreement that identifies what support a self-directing beneficiary may want or need.

Enrollment Requirements
Each potential AWC FMS entity must meet the following requirements:

- ~~SRS/KDOA~~ Provider Agreement
    - Applications are available on the DCF website at http://www.dcf.ks.gov/Pages/default.aspx.
    - The application must be completed and returned as indicated on the agreement ~~identified on the website~~.

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FINANCIAL MANAGEMENT SERVICES
Enrollment Requirements (continued)

- The application must be complete. The submission of an incomplete application or the failure to provide the required documentation will result in pending the application to await completion of the documentation. ~~Incomplete applications or the failure to provide required documentation will result in pending the application to await completed documentation.~~
- KDADS Provider Agreements are valid for the terms specified in the agreement ~~three years~~ unless revoked, withdrawn, or surrendered.
- Renewal of the provider agreement is subject to approval by KDADS, pending the applicant meeting all financial audit requirements.

Each potential AWC FMS entity must complete and maintain in good standing:

- Medicaid Provider Agreement
  - The Medicaid Provider Agreement can only be obtained upon the presentation of a valid, approved KDADS Provider Agreement.
  - Medicaid provider requirements are available on the KMAP website.
- Registration with the secretary of state's office, if required, including the following:
  - The entity must be in good standing with all Kansas laws/business requirements.
  - Owners/principles/administrators/operators must have no convictions of embezzlement, felony theft, or fraud.
  - Owner, primary operator, and administrator of the FMS business must live in a separate household from beneficiaries receiving services from the FMS business.
  - Business is established to provide FMS to more than one beneficiary.
- Insurance, defined as:
  - Liability insurance (annual liability with a $500,000 minimum)
  - Workers compensation insurance
    - Covers all workers
    - Meets all requirements of the State of Kansas
    - Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
  - Unemployment insurance
  - Other insurances (if applicable)
- Annual independent financial audit (contracted by all FMS providers)
- Financial solvency with evidence that 30 days coverage of operational costs are met

  Note: Cash requirements will be estimated using the past quarter's performance from the date of review, or, if a new entity, the provider must estimate the number of beneficiaries that they reasonably expect to serve using nominal costs.

  Evidence may include the following:
  - Cash (last three bank statements)
  - Open line of credit (statement[s] from bank/lending institution)
  - Other (explain)

8400. BENEFITS AND LIMITATIONS Updated 04/14

FINANCIAL MANAGEMENT SERVICES
Enrollment Requirements (continued)

- Required policies and procedures including, but not limited to:
    - Policies and procedures for billing Medicaid, in accordance with approved rates, for services authorized on the POC
    - Policies and procedures for billing FMS administrative fees
    - Policies and procedures to receive and disburse Medicaid funds, track disbursements, and provide reports
        - Semi-annual reports to self-directed beneficiaries for billing/disbursements on their behalf
        - Report to the State of Kansas, as requested
    - Policies and procedures to ensure proper/appropriate background checks are conducted on all individuals (FMS providers and direct support workers) in accordance with program requirements
    - Policies and procedures to ensure self-directing beneficiaries follow the pay rate procedures established by the State of Kansas when setting direct support workers' pay rates
        - Clear identification of how this will occur
        - Prohibition of wage/benefit setting by FMS provider
        - Prohibition of "recruitment" of self-direct individuals (HCBS waiver beneficiaries and/or direct support worker staff) by enticements or promises of better wages and/or benefits through the improper use of Medicaid funds
    - Policies and procedures to ensure proper/appropriate processing of time worked, disbursing of pay checks, filing of taxes, and other associated responsibilities
    - Policies and procedures regarding the provision of I&A services
    - Policies and procedures for grievance
      Note: The grievance policy is designed to ensure direct support workers can address relevant issues, such as hours paid differing from hours worked, lack of timely pay checks, bounced pay checks, and other FMS-related issues.

Reimbursement

- One unit equals one month.
- Maximum unit cost equals $115.
- Procedure code: T2040 U2

Documentation Requirements

Written documentation is required for services provided and billed to the KanCare contracted health plans. Documentation must be clearly written and self-explanatory or reimbursement may be subject to recoupment. ~~Documentation is required for services provided and billed to KMAP. For a postpayment review, reimbursement will be recouped if documentation is not complete.~~

Documentation requirements also apply to those limited instances where the beneficiary does not have telephone (landline or cell) access **and** an exception is granted by KDADS. Written documentation needs to be a report, database, spreadsheet, or invoice.

8400. BENEFITS AND LIMITATIONS Updated 04/14

FINANCIAL MANAGEMENT SERVICES
Documentation Requirements (continued)

Written and electronic documentation must, at a minimum, include the following:

- Identification of the FMS and/or I&A services
- Beneficiary's printed name (first and last)
- Identification of the authorized FMS provider
- Beneficiary's Medicaid identification number
- Date of service (MM,DD,YYYY)
- Notes of any I&A tasks provided during contacts within the month

- ~~Start time for each visit, include AM/PM or use 2400 clock hours~~
- ~~Stop time for each visit, include AM/PM or use 2400 clock hours~~

The beneficiary's ~~printed name and~~ signature must be on the completed Service Agreement prior to the start of service delivery. In the case of electronic documentation, the beneficiary's signature authorizing the use of the electronic documentation system at the start of service delivery is required.

Electronic documentation of service delivery is allowed when meeting both documentation and signature standards as outlined above.

Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment. For postpayment review, reimbursement will be recouped if documentation is not complete.

Limitations

- The beneficiary or beneficiary's representative cannot receive payment for the administrative functions he or she may perform.
- Only one FMS provider is to be authorized on a POC per month.
- Access to this service is limited to beneficiaries or their representatives who direct some or all of their services.

Expected Service Outcomes for Individuals or Agencies Providing HCBS FMS Services

Created 04/14

1. Services are provided according to the POC, in a quality manner, and as authorized on the Notice of Action.

2. Provision of services is coordinated in a cost-effective and quality manner.

3. Beneficiary's independence and health are maintained, where possible, and in a safe and dignified manner.

4. Beneficiary's concerns and needs, such as changes in health status, are communicated to the managed care organization (MCO) care coordinator ~~case manager~~ within 48 hours, including any ongoing reporting as required by the Medicaid program.

5. Any failure or inability to provide services as scheduled in accordance with the POC must be reported immediately, but at least within 48 hours, to the MCO care coordinator ~~case manager~~.