Kansas Medical Assistance Program

KANSAS MEDICAL ASSISTANCE PROGRAM

PROVIDER MANUAL

HCBS Autism

HCBS AUTISM PROVIDER MANUAL

Introduction

FORMS All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp under Pricing and Limitations.

PART II
INTRODUCTION TO THE HCBS AUTISM PROVIDER MANUAL

Updated 12/10

The Home and Community Based Services (HCBS) waiver for children with autism is designed for Medicaid-eligible children from zero through five years of age (at the time of the application) who are at risk of admission to an inpatient psychiatric facility for individuals under 21 years of age ~~state mental health hospital~~. To be eligible for HCBS autism waiver services, the child must have a diagnosis of autism spectrum disorder (ASD) including autism, Asperger's syndrome, and other pervasive developmental disorder-not otherwise specified from a licensed medical doctor or PhD psychologist who uses an approved autism-specific screening tool. The child must also meet the functional criteria using the Vineland II Survey Interview Form and meet the financial (Medicaid) criteria.

The waiver provides opportunities for children with ASD to receive intensive early intervention treatment and their primary caregivers to receive assistance and support.

Services offered under the HCBS autism waiver are:

- Consultative clinical and therapeutic services (provided by an autism specialist)
- Family adjustment counseling
- Intensive individual supports
- Interpersonal communication therapy
- Parent support and training (peer-to-peer)
- Respite care

This is the provider specific section of the provider manual. This section (Part II) is designed to provide information specific to providers of HCBS autism waiver services and is divided into three sections: Billing Instructions, Benefits and Limitations, and Appendix~~, and Forms~~. Part I of the provider manual consists of five parts: General Information, General Benefits, General Billing, General Special Requirements, and General TPL Payment. Part I contains information that applies to all providers, including HCBS autism waiver providers.

The **Billing Instructions** section provides instructions on submitting a claim.

The **Benefits and Limitations** section outlines services included for HCBS autism waiver beneficiaries and limitations on these services. It also includes qualifications for HCBS autism waiver providers, documentation required for reimbursement, and expected service outcomes.

The **Appendix** section contains information concerning ~~procedure~~ codes. The appendix was developed to make finding and using ~~procedure~~ codes easier for the biller.

~~The **Forms** section includes a sample of the CMS-1500, which must be completed for reimbursement of services.~~

PART II
INTRODUCTION TO THE HCBS AUTISM PROVIDER MANUAL

Updated 12/10

HIPAA Compliance

As a participant in the KHPA Medical Plans, 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 by the Department during its review and investigation.

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to the KHPA Medical Plans upon request. Providers must also supply records to the Department of Health and Human Services upon request.

The provider is required to supply records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844 to 21-3855, inclusive, as amended.

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 the provider’s employees. The provider shall not charge a fee to retrieve and copy documents and records related to compliance reviews and complaint investigations.

HCBS AUTISM BILLING INSTRUCTIONS

7000. Updated 12/10

Introduction to the CMS-1500 Claim Form

HCBS autism waiver providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services provided under the KHPA Medical Plans. Any CMS-1500 claim form not submitted on the red claim form will be returned to the provider. An example of the CMS-1500 claim form is ~~in the Forms section at the end of this manual~~ on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp. The interChange Medicaid Management Information System (MMIS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information must be submitted in the correct claim fields to be recognized by the equipment.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to Section 1100 of the *General Introduction Provider Manual*.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the *General Billing Provider Manual.*

Submission of Claim

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

KHPA Medical Plans
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

HCBS AUTISM SPECIFIC BILLING INFORMATION

7010. Updated 12/10

Enter the appropriate ~~procedure~~ code in field 24D of the CMS-1500 claim form. See the Appendix section for an all inclusive list of HCBS autism waiver ~~procedure~~ codes.

Time Keeping
Time must be totaled by actual minutes/hours worked. Billing staff may round the total at the end of the billing cycle to the nearest one-half unit. One unit equals 8 through 15 minutes; one-half unit (.5 unit) equals up to and including 7 minutes. Providers are responsible to ensure the services were provided prior to submitting claims.

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

Note: Client obligation is assigned only to the HCBS autism waiver services included on the MMIS plan of care.

One Plan of Care a Month
Prior authorizations through the plan of care process are approved for one month only. Dates of service that span two months must be billed on two separate claims.

> **Example**
> Services for July 28 – August 3 must be billed with July 28 – 31 on one claim and August 1 – 3 on a second claim.

Overlapping Dates of Service
The dates of service on the claim must match the dates approved on the plan of care and cannot overlap. For example, there are two lines on the plan of care with the following dates of service:
July 1 – 15 and July 16 – 31. If a provider bills service dates of July 8 – 16, the claim will deny because the system is trying to read two different lines on the plan of care. For the first service line, any date that falls between July 1 – 15 will prevent the claim from denying for date of service.

Same Day Service
For certain situations, HCBS waiver services approved on a plan of care and provided on the same day a beneficiary is hospitalized or in a state mental hospital may be allowed. Situations are limited to HCBS waiver services provided on the date of admission, if provided prior to the beneficiary being admitted.

8100. COPAYMENT Updated 12/10

HCBS autism waiver services are exempt from copayment requirements.

8300. BENEFIT PLANS Updated 12/10

KMAP beneficiaries are assigned to one or more KMAP benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

8400. MEDICAID Updated 12/10

HCBS Autism Waiver Program
For the purposes of this waiver, "family" is defined as the persons who live with or provide care to a child served on the waiver and may include a parent, stepparent, legal guardian, sibling's relatives, grandparents, or foster parents.

The information obtained from the Vineland-II and the assessment of the family's needs and strengths is used to develop the individualized behavioral program/plan of care (IBP/POC). The child, family and autism specialist work together to develop the IBP/POC which identifies the supports needed, who is responsible for meeting those needs, the amount of services approved to meet those needs, and the amount the provider(s) are reimbursed to meet those needs. Once the POC is approved, the child and family can begin receiving services. To maintain eligibility, the beneficiary must meet both financial and functional criteria annually. Annual reviews are conducted to determine continued eligibility for a maximum of three years with a potential for a one-year extension.

See Community Supports and Services' (CSS') *HCBS Autism Waiver Policy and Procedure Manual* for additional information.

All HCBS autism waiver services, except the services provided by the autism specialist, require prior authorization through the POC process.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

Enrollment
Potential providers must complete a KMAP provider enrollment application and submit their credentials and qualifications with the application. The fiscal agent reviews the application and forwards the application to the HCBS autism waiver program manager. Once the program manager determines the provider meets the qualifications, the fiscal agent notifies the potential provider of the enrollment determination and supplies a copy of the *HCBS Autism Provider Manual*.

8400. MEDICAID Updated 12/10

Consultative Clinical and Therapeutic Services (provided by an autism specialist)
Submit ~~procedure~~ code H2015 to bill for these services.

These therapeutic services focus on remediation of behavioral symptoms related to the diagnosis of ASD. They teach adaptive skills which assist the family and paid support staff or other professionals with carrying out the IBP/POC. The autism specialist supports the family and child's functional development and inclusion in the community. The autism specialist assesses the child and family's strengths and needs, develops the IBP/POC, coordinates services, provides training and technical assistance, and monitors the child's progress within the program.

Assessment of an eligible child through the use of a criterion reference skill-based assessment determines the service needs by:

- Taking the child's history
- Identifying the child's needs and completing the related documentation
- Gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the child

Development of an IBP/POC in conjunction with the child and family that:

- Is based on the information collected through the assessment
- Specifies the goals and actions necessary to address the medical, social, educational, and other service needs of the child
- Includes activities that ensure active participation of the child and family

Documentation must support that the autism specialist has coordinated services to help the child and family obtain needed services including activities that help link the child with medical, social, and educational providers.

Training and technical assistance to the family and paid support staff is driven by the IBP/POC. The POC may document both waiver and nonwaiver services (some of which may not be Medicaid-reimbursable, such as the Head Start program).

The teaching of adaptive skills is based on evidence-based practices proven to be effective in the treatment of ASD. Postimplementation of the POC includes monitoring and follow-up activities and a review of the IBP/POC at a minimum of every six months with documentation of progress toward stated goals. If progress is not demonstrated, documentation must support a reason for pursuing these goals or a change in the goals must be made. The review process may involve the child, family members, providers, or other entities and are conducted as frequently as necessary but not less than every six months to determine whether:

- Services are being furnished in accordance with the child's IBP/POC.
- Services in the IBP/POC are adequate to maintain an appropriate level of care.
- Service authorizations are adequate to support the delivery of needed services.
- Changes in the needs or status of the child exist and, if so, adjusting the POC and making the appropriate service arrangements with the providers.
- Obstacles exist which impede or limit the delivery of services and, if so, taking action to remove them.

8400. MEDICAID Updated 12/10

Consultative Clinical and Therapeutic Services (provided by an autism specialist) continued
Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

The autism specialist is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Documentation ***at a minimum*** must include the following***:***

- Current assessment or reassessment
- POC dated and signed by the parent or guardian
- Notice of Action sent by the autism specialist
- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of autism specialist, legibly printed, with signature on each page verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.

Services provided must be documented within the billed time frame.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above is included in the rate paid to providers of this service.

Limitations

- Persons with family relationships to the beneficiary cannot be the assigned autism specialist.
- The maximum allowable units per child are 200 units per calendar year. This limitation may be waived with prior authorization by the autism waiver program manager.

8400. MEDICAID Updated 12/10

<u>Consultative Clinical and Therapeutic Services (provided by an autism specialist)</u> continued
Provider Requirements

- The provider must be a KMAP provider enrolled as an autism specialist to bill consultative clinical and therapeutic services.
- Community service providers billing this service must be licensed by Disability Behavior and Health Services (DBHS) ~~HCP~~/CSS.
- Community mental health centers billing for this service must be licensed under K.A.R. 30-60-1.
- The provider must have a master's degree, preferably in human services or education, or be a board-certified behavior analyst (BCBA) with documentation of 2,000 hours of supervised experience working with a child with ASD.
- The provider must participate in all state-mandated HCBS autism waiver training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS ~~HCP~~/CSS training and professional development requirements; and maintenance of clear background as evidenced through the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid Registry, and motor vehicle screens.

Note: An exception can be requested to the Kansas Department of Social and Rehabilitation Services (SRS) to waive 1,000 hours of the required experience for individuals who are BCBAs.

8400. MEDICAID Updated 12/10

Family Adjustment Counseling

Submit ~~procedure~~ code S9482 to bill family adjustment counseling services at an individual rate.
Submit ~~procedure~~ code S9482 HQ to bill family adjustment counseling services at a group rate.

Family adjustment counseling services are designed for family members of a child with ASD. These services offer guidance and assistance in coping with the child's illness and daily needs. As the family learns to manage these stressors, the child has a greater likelihood of continuing to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family adjustment counseling offers a safe and supportive environment to express emotions and ask questions. When acceptance of the disorder can be achieved, the family is prepared to support the child on an ongoing basis. These services are provided by a licensed mental health professional (LMHP) who is responsible for maintaining an ongoing collaborative relationship with the autism specialist beginning at the time of the referral.

Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's IBP/POC.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

The family adjustment counseling provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

No more than one family adjustment counseling provider may be paid for services at any given time of day.

Documentation

Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Documentation ***at a minimum*** includes:

- The service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided

Family Adjustment Counseling continued
Documentation continued

- Name of family adjustment counseling service provider, legibly printed, with signature verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.

Services provided must be documented within the billed time frame.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above are included in the rate paid to providers of this service.

Limitations

- Persons with family relationships to the beneficiary cannot provide family adjustment counseling services.
- The maximum allowable units per child are 48 units per calendar year. This limit applies whether it is an individual or group rate or a combination of individual and group services.
- Services must be recommended by an autism specialist, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's IBP/POC.
- A group setting cannot consist of more than three families.
- The group membership requirement for family adjustment counseling is to have a family member with a diagnosis of ASD.
- Families must agree to a group setting.
- Services cannot duplicate any service included under the Individuals with Disabilities Education Improvement Act (IDEA) or the Rehabilitative Services Act of 1973 (per 1915 c).

Reimbursement

Payment for family adjustment counseling services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- The provider must be a KMAP-enrolled provider for family adjustment counseling.
- Community service providers billing this service must be licensed by DBHS ~~HCP~~/CSS.
- Community mental health centers billing this service must be licensed under K.A.R. 30-60-1.
- The performing provider must be a licensed mental health professional (LMHP) and must hold a current license to practice in the State of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564.

8400. MEDICAID Updated 12/10

Family Adjustment Counseling continued
Provider Requirements continued

- The provider must maintain an ongoing collaborative relationship with the autism specialist beginning at time of referral.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS ~~HCP~~/CSS training and professional development requirements; and maintenance of clear background as evidenced through KBI, APS, CPS, Nurse Aid Registry, and motor vehicle screens.

8400. MEDICAID Updated 12/10

Intensive Individual Supports
Submit ~~procedure~~ code H2019 to bill these services.

Intensive individual supports services are identified on the POC. They are services provided to a child with ASD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Services are provided through evidence-based and data-driven methodologies. Intensive individual supports include the development of skills such as:

- Social skills to enhance participation in family, school, and community activities (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
- Expressive verbal language, receptive language, and nonverbal communications skills
- Functional symbolic communication system
- Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system
- Fine and gross motor skills used for age-appropriate functional activities, as needed
- Cognitive skills, including symbolic play and basic concepts, as well as academic skills
- Conventional and appropriate behaviors in place of negative behavior patterns
- Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instructions in a group, or asking for help)

The majority of these contacts must occur in customary and usual community locations where the child lives, attends school or child care, and/or socializes. Services provided in an educational setting must not be educational in purpose.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

The intensive individual supports provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

No more than one individual support service worker may be paid for services at any given time of day.

Documentation
Documentation must directly relate to the child's POC. It must include information relating to the access, appropriateness, and coordination of supports and services. Sources of information can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Intensive Individual Supports continued
Documentation continued
Documentation ***at a minimum*** includes:

- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of intensive individual supports service provider, legibly printed, with signature on each page verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.

Services provided must be documented within the billed time frame.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above are included in the rate paid to providers of this service.

Limitations

- Persons with family relationships to the beneficiary cannot provide intensive individual supports services.
- The maximum allowable units per child are 100 units per week per calendar year.
- Services must be identified in the child's IBP/POC.
- Services will not duplicate any service included under Individuals with Disabilities Education Improvement Act (IDEA) or the Rehabilitative Services Act of 1973 (per 1915 c).

Reimbursement
Payment for intensive individual supports cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- The provider must be a KMAP-enrolled provider for intensive individual supports.
- Community service providers billing this service must be licensed by DBHS ~~HCP~~/CSS.
- Community mental health centers billing for this service must be licensed under K.A.R. 30-60-1.
- Performing providers of this service must have a bachelor's degree, preferably in human services or education, or 60 college credit hours and 1,000 hours experience working with a child with ASD.
- The provider must participate in all state-mandated HCBS autism waiver training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program.

8400. MEDICAID Updated 12/10

Intensive Individual Supports continued
Provider Requirements continued

- The provider must work under the direction of the autism specialist.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS ~~HCP~~/CSS training and professional development requirements; and maintenance of clear background as evidenced through KBI, APS, CPS, Nurse Aid Registry, and motor vehicle screens.

8400. MEDICAID Updated 12/10

Interpersonal Communication Therapy (provided by a licensed speech language pathologist)
Submit code G0153 to bill for these services.

These therapy services work toward remediation of social communication symptoms related to the diagnosis of an autism spectrum disorder and are provided through evidence-based methodologies. The autism specialist identifies any needed services and the providers who can meet these needs through the development of an individualized POC. The IBP/POC is used to delineate the specific objectives and goals for the various team members. The specialist performing the interpersonal communication therapy (ICT) service evaluates and identifies the necessary communication needs of the child on an ongoing basis. The intensive individualized supports provider implements the interventions identified in the IBP/POC by the autism specialist in consultation with the ICT provider. ICT includes the development of skills such as:

- Conversation skills
- Spontaneous communication in functional activities across social partners and settings
- Comprehension of verbal and nonverbal discourse in social and community settings
- Communication for a range of social functions that are reciprocal
- A functional communication system

The majority of these contacts must occur in customary and usual community locations where the child lives, goes to child care, and/or socializes.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for person with mental retardation, or institution for mental disease are noncovered.

The ICT provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements. Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Documentation ***at a minimum*** must include the following:

- Current or updated evaluation
- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of ICT provider, legibly printed, with signature on each page verifying that every entry reflects activities performed

Interpersonal Communication Therapy (provided by a licensed speech language pathologist)
Documentation continued

- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed. Services provided must be documented within the billed time frame.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above are included in the rate paid to providers of this service.

Limitations

- Persons with family relationships to the beneficiary cannot provide ICT services.
- The maximum allowable units per child are eight units per calendar week.
- Services must be identified in the child's IBP/POC.
- Services must be recommended by an autism specialist and physician.
- A physician's order must be written for services and maintained in the provider case file. It is subject to prior approval and must be intended to achieve the goals or objectives identified in the child's IBP and POC.
- Services cannot duplicate any service included under the Individuals with Disabilities Education Improvement Act (IDEA) or the Rehabilitative Services Act of 1973 (per 1915 c).

Reimbursement

Payment for ICT cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- The provider must be KMAP-enrolled provider for ICT.
- A community and/or private speech-language clinic performing provider must be a licensed speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association.
- The performing provider must be a licensed speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association and 1000 hours of experience working with a child with ASD.
- The provider must participate in all state-mandated HCBS autism training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS/CSS training and professional development requirements; and maintenance of clear background as evidenced through KBI, APS, CPS, Nurse Aid Registry, and motor vehicle screens.

8400. MEDICAID Updated 12/10

Parent Support and Training (Peer to Peer)
Submit ~~procedure~~ code T1027 to bill parent support and training services at an individual rate.
Submit ~~procedure~~ code T1027 HQ to bill parent support and training at a group rate.

Parent support and training services promote the engagement and active participation of family members in all aspects of the treatment process. These services increase the potential for a safe and supportive environment in the home and community for the child. The family can acquire the knowledge and skills necessary to understand and address the specific needs of the child in relation to ASD and related treatments. These services also develop and enhance the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management.

The parent support and training provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

No more than one parent support and training worker may be paid for services at any given time of day.

Documentation
Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Documentation ***at a minimum*** includes:

- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of parent support and training service provider, legibly printed, with signature on each page verifying that every entry reflects activities performed
- Detailed description of the service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.

Parents Support and Training (Peer to Peer) continued

Services provided must be documented within the billed time frame. Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above are included in the rate paid to providers of this service.

Limitations

- Persons with family relationships to the beneficiary cannot provide parent support and training services.
- The maximum allowable units per child are 120 units per calendar year. This limit applies whether it is an individual or group rate or a combination of individual and group services.
- Services must be recommended by an autism specialist, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's IBP/POC.
- Group settings cannot consist of more than three families.
- The group membership requirement for parent support and training is to have a family member with a diagnosis of ASD.
- Families must agree to a group setting.

Reimbursement

Payment for parent support and training services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- The provider must be KMAP-enrolled provider for parent support and training.
- Community service providers billing for this service must be licensed by DBHS ~~HCP~~/CSS.
- Community mental health centers billing for this service must be licensed under K.A.R. 30-60-1.
- Performing providers of this service must have a high school diploma or equivalent.
- The provider must be 21 years of age or older.
- The provider must have three years of direct care experience working with a child with ASD or be the parent of a child with ASD.
- The provider must participate in all state-mandated HCBS autism training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program.
- The provider must work under the direction of the autism specialist.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS ~~HCP~~/CSS training and professional development requirements; and maintenance of clear background as evidenced through KBI, APS, CPS, Nurse Aid Registry, and motor vehicle screens.

8400. MEDICAID Updated 12/10

Respite Care

Submit ~~procedure~~ code T1005 to bill these services.

Respite care services provide temporary direct care and supervision of the child. The primary purpose is to provide relief to families and caregivers of a child with ASD. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Assistance with normal activities of daily life is considered content of service and includes support in home and community settings.

The respite care provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are noncovered.

No more than one respite care provider may be paid for services at any given time of day.

Documentation

Documentation must directly relate to the child's POC. This includes information about the access, appropriateness, and coordination of supports and services. Sources of information to be documented can include contacts with the person receiving services, family members, legal representatives, service providers, and other interested parties. Documentation must provide the necessary details to meet federal and state requirements.

Documentation must be legible, accurate, and timely. A beneficiary's file may be requested for review by the state program manager for quality assurance reviews.

Documentation ***at a minimum*** includes:

- Service being provided
- Child's first and last name on each page
- Date of service (MM/DD/CCYY)
- Location of service provided
- Name of respite care service provider, legibly printed, with signature on each page verifying that every entry reflects activities
- Signature of parent or legal guardian to verify services were received as documented
- Type of service provided, including start and stop times that indicate AM/PM or use 2400 hour clock

Note: Time spent must be clearly documented in the notes. Providers are responsible to ensure the services were provided prior to submitting claims.

If documentation is not clearly written and self-explanatory, the services billed may not be reimbursed.

Services provided must be documented within the billed time frame.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above are included in the rate paid to providers of this service.

8400. MEDICAID Updated 12/10

Respite Care continued

Limitations

- Respite care services are available to participants with a family member who serves as the primary caregiver and is not paid to provide any HCBS autism waiver service to the child.
- The maximum allowable units per child are 672 units per calendar year.
- Respite care cannot be provided by a parent of the child.
- Services must be recommended by an autism specialist, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's IBP/POC.
- Services cannot duplicate any service included under IDEA or the Rehabilitative Services Act of 1973 (per 1915 c).
- Respite care is provided in planned or emergency segments and may include payment during the beneficiary's sleep time.

Reimbursement

Payment for respite care services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Provider Requirements

- The provider must be a KMAP-enrolled provider for respite care.
- Community service providers billing for this service must be licensed by DBHS ~~HCP~~/CSS.
- Community mental health centers billing for this service must be licensed under K.A.R. 30-60-1.
- Performing providers of this service must have a high school diploma or equivalent.
- The provider must be 18 years of age or older.
- The provider must meet family's qualifications.
- The provider must reside outside of child's home.
- The provider must participate in all state-mandated HCBS autism waiver training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program.
- The provider must work under the direction of the autism specialist.
- The provider must maintain all standards, certifications, and licenses required for the specific professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS ~~HCP~~/CSS training and professional development requirements; and maintenance of clear background as evidenced through KBI, APS, CPS, Nurse Aid Registry, and motor vehicle screens.

APPENDIX

CODES

Updated 12/10

The following procedure codes represent an all-inclusive list of HCBS autism waiver services billable to the KHPA Medical Plans for HCBS autism waiver beneficiaries. Procedures not listed here are considered noncovered.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website is available at: https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp.
- Information from the secure website is available under Pricing and Limitations after logging on at: https://www.kmap-state-ks.us/provider/security/logon.asp.

A chart has been developed to assist providers in understanding how KHPA will handle specific modifiers. The Coding Modifiers chart is available on both the public and secure websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information on the American Medical Association is available at http://www.ama-assn.org.

CONSULTATIVE CLINICAL AND THERAPEUTIC SERVICES
H2015

FAMILY ADJUSTMENT COUNSELING
S9482

S9482 HQ

INTENSIVE INDIVIDUAL SUPPORTS
H2019

INTERPERSONAL COMMUNICATION THERAPY
G0153

PARENT SUPPORT AND TRAINING SERVICES
T1027

T1027 HQ

RESPITE CARE
T1005