Kansas
Medical Assistance
Program

KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Nursing/Intermediate Care Facility Manual
Intermediate Care Facility – Mental Retardation
Nursing Facility
Nursing Facility – Mental Health

PART II
NURSING/INTERMEDIATE CARE FACILITY PROVIDER MANUAL

Introduction

Forms

PART II
NURSING/INTERMEDIATE CARE FACILITY PROVIDER MANUAL
Updated 6/06

This is the provider specific section of the manual. This section (Part II) provides instructions, limitations, and requirements for nursing facilities (NFs), nursing facilities for mental health (NFs/MH), and intermediate care facilities for mental retardation (ICFs/MR). It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection gives directions for completing and submitting each specific form. Sample billing forms are in Forms section.

The **Benefits and Limitations** subsection defines specific aspects of the scope of nursing facility services allowed within the Kansas Medical Assistance Program (KMAP).

HIPAA Compliance
As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services (DHHS) 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 DHHS all information required by the Department during its review and investigation. The provider is required to provide the same forms of 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 shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. NF CMS-1500 BILLING INSTRUCTIONS Updated 05/08

See Forms section for an example of the form.

Introduction to the CMS-1500 Claim Form

Nursing facilities ~~billing for Central Supply Oxygen~~ must use the CMS-1500 claim form or accepted electronic equivalent when requesting payment for medical services and supplies provided under KMAP. An example of the CMS-1500 claim form is in the Forms section at the end of this manual. The interChange MMIS uses electronic imaging and optical character recognition (OCR) equipment. Information must be submitted in the correct fields as instructed 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 claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

7010 NF ~~HCFA-1500~~ CMS-1500 BILLING INFORMATION
Updated 05/07

Automated Processing of Nursing Facility and ICF-MR Room and Board Charges for Hospice Beneficiaries.

Hospice providers are required to bill the room and board charges for hospice recipients residing in NFs, ICF/MRs, or hospital swing beds. NFs include skilled nursing facilities, nursing facilities and nursing facilities for mental health. ICF/MRs include both privately owned and state institution ICF/MRs. These claims may be submitted on paper, electronically, or through the Internet. Automated processing will allow these claims to process quickly and accurately by following the instructions below.

- **Paper Claims**: Complete the claim as usual and in ***box 17a*** document the NF, ICF/MR, or hospital swing bed provider number.
- **Electronic Claims (for example, 837P)**: Complete the claim as usual and document the NF, ICF/MR, or hospital swing bed provider number in the ***referring provider*** field. **Providers using third party software may use the referring physician field at the header or detail level.**
- **Web Claims**: Complete the claim as usual and document the NF, ICF/MR, or hospital swing bed provider number in the ***referring physician*** field.

Although swing bed room and board claims are not automated at this time, processes have been implemented to expedite swing bed room and board claims processing utilizing the referring provider fields noted above.

Claims submitted after January 1, 2005 without a valid referring provider number in the designated field, will be denied.

7020 NF UB-04 BILLING INSTRUCTIONS
Updated 05/08

Introduction to the UB-04 Claim Form

NF providers must use the UB-04 claim form or accepted electronic equivalent when requesting payment for NF services ~~or supplies~~.

If the stay meets Medicare coverage criteria, Medicare reimburses the nursing facility for the first 20 days and there is no coinsurance or deductible. If, after the 20th day, the stay is still covered by Medicare, days 21 to 100 are reimbursed by KMAP for all but the Medicare coinsurance and deductible. This coinsurance and deductible can be billed to KMAP on the UB-04 claim form using your KMAP provider number and indicating the Type of Bill (TOB) 21X or 6IX after Medicare has paid its eligible portion.

Medicare Coinsurance Claims

- File a crossover claim with the fiscal agent, which is on a UB-04 claim form, with the Medicare explanation of benefits (EOB) attached. If the fiscal intermediary is Mutual of Omaha, file a hard copy of the UB-04 claim form and EOB.
- Do not put Medicare payment information in the "Other Insurance" field, or the claim will be denied.
- The claims submitted must be on a paper UB-04 claim form or may be billed through Provider Electronic Solutions (PES).
- The fiscal agent processes the claim. KMAP either pays the claim or returns the HIPAA remark code 23 or 42 and the EOB 0095 on the remittance advice stating the claim is paid zero dollars because Medicare paid the maximum allowable.
- HIPAA remark codes 23 or 42 will allow the KMAP coinsurance balances to be used for write-off as Medicare bad debt.

If the claim contains room and board with ancillary services **and** the provider received **Part A and B** payment, the claim will be processed through the Medicare Algorithm for the **Part A** payment and **Part B** payment will be applied as a TPL payment. If the provider bills only ancillary services, those claims will be denied as content of service to the room and board claim.

An example of the UB-04 claim form is in the Forms section at the end of this manual. The fiscal agent does not furnish the UB-04 claim form to providers. Refer to Section 1100 of the *General Introduction Provider Manual* for more information.

The interChange MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized if not submitted in the correct fields as instructed.

Billing Instructions

The following numbered form locator (FL) fields are to be completed when required or if applicable as follows, or KMAP will deny the claim.

FL 1 **Billing Name and Address.** Enter the name and address of the billing provider.

FL 3a **Patient Account Number.** Enter the beneficiary's account number, if desired. This number will be referenced on the RA.

FL 3b **Medical Record Number – Desired.** Enter a medical record number, if desired.

FL 4 **Type of Bill – Required**. Enter the three-digit number specific to the type of claim.

KMAP allowed codes for nursing facilities

1st digit: 2 – Intermediate care facility
6 – Skilled nursing facility

2nd digit: 1 – Inpatient

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

FL 6 **Statement Covers Period ~~– From/Through – Required~~.** Enter inpatient dates of admission and discharge or outpatient from and through dates in MM/DD/CCYY format.

FL 7 **Covered Days – Required – Inpatient Only.** Enter the number of days for which you are billing.

FL 8b **Patient Name.**
a – Not required
b – Enter patient name

FL 10 **Birthdate.** Enter patient's date of birth in MM/DD/YYYY format. Enter D3 for nonpatient obligation as the value code. Enter the nonpatient obligation dollar amount in the "Amount" field. Examples of nonpatient obligation are parental, spousal and trust.

FL 12 **Admission Date. ~~Patient Name – Required.~~** Enter the date the beneficiary was admitted or date of outpatient care in MM/DD/YYYY format. Nursing home providers should enter the original facility admission date. ~~the beneficiary's last name, first name, and middle initial exactly as it appears on the medical ID card~~.

FL 14 **Admission Type. ~~Birth Date – Required~~**. Enter a one-digit code to indicate type of admission. Required for inpatient only.
1 – Emergency
2 – Urgent
3 – Elective
4 – Newborn
5 - Trauma
~~the beneficiary's date of birth in MM/DD/CCYY format.~~

FL 15 **Admission Source – Required.** Enter a one-digit code to indicate admission source.

4 – Transfer from hospital
5 – Transfer from nursing home
6 – Transfer from another facility

FL 17 **Patient Discharge Status.** ~~**Admission Date – Required.**~~ Enter the two-digit code to indicate the patient status. ~~the original facility admission date in MM/DD/CCYY format.~~

FL 18 **Condition Codes.** Enter one of these two-digit codes to indicate a condition(s) relating to inpatient or outpatient claims, special programs or procedures. This is not a complete list.

~~**FL 22 Stat – Required,** Enter a two-digit code to indicate the patient's status:~~

~~01 Discharged to home or self care (routine discharge).~~
~~03 Discharged or transferred to skilled nursing facility with Medicare certification.~~
~~04 Discharged or transferred to intermediate care facility.~~
~~05 Discharge/transfer to a designated cancer center or children's hospital.~~
~~06 Discharged or transferred to a home under the care of a home health service organization.~~
~~07 Left against medical advice or discontinued care.~~
~~08 Discharged or transferred to a home under care of a home IV drug therapy provider. This is not a certified Medicare provider.~~
~~20 Expired or deceased.~~
~~30 Still a patient.~~
~~43 Discharged or transferred to a federal health care facility.~~
~~50 Discharged to hospice – home.~~
~~51 Discharged to hospice – medical facility.~~
~~61 Discharged or transferred to a hospital-based, Medicare-approved swing bed.~~
~~62 Discharged or transferred to an inpatient rehabilitation facility including rehabilitation distinct units of a hospital.~~
~~63 Discharged or transferred to a Medicare certified nursing facility.~~
~~64 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare.~~
~~65 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (for future use). Providers shall continue to use Patient Status code 05 until further notice.~~
~~66 Discharged or transferred to a critical access hospital for discharge dates on and after January 1, 2006.~~
~~70 Discharge/transfer to another type of health care institution not defined elsewhere in the code list.~~

~~**FL 23 Medical Record No. – Desired.** Enter the beneficiary's medical record number. This number will appear on the provider's Remittance Advice.~~

~~**FL 24-30 Condition Codes – Desired.** Enter one of these two-digit codes to indicate condition(s) relating to inpatient or outpatient claims, special programs, or procedures (such as KAN Be Healthy or sterilization).~~

~~01 Military service related~~
~~02 Employment related~~
~~03 Patient covered by insurance not reflected here~~
~~67 Beneficiary elects not to use life time reserve (LTR) days~~
~~***Note:*** This code replaces the Z1 Medicare Part A benefits exhausted condition code. The verbiage in the explanation of condition code 67 means the patient's benefits are exhausted~~
~~80 Home dialysis – nursing facility~~
~~A1 KAN Be Healthy (EPSDT)~~
~~A4 Family planning~~
~~AA Abortion performed due to rape~~
~~AB Abortion performed due to incest~~
~~AI Sterilization~~
~~D9 Any other change~~
~~***Note:*** This code replaces the XO swing bed condition code.~~

FL 31-34 Occurrence Codes/Dates. Occurrence codes can only be submitted on Line A. The following occurrence codes must be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPR termination, or aborted surgery, false labor or nondelivery claim where associated services are indicated.

~~**FL 32-35 Occurrence Codes/Dates – Desired.** Occurrence codes can only be submitted on Line A. The following occurrence codes **must** be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPR termination, or aborted surgery, false labor, or nondelivery claim where associated services are indicated.~~

~~01 Accident/medical coverage~~
~~02 No fault insurance involved including auto accident or other~~
~~03 Accident or tort liability~~
~~04 Accident or employment related~~
~~05 Accident or no medical or liability coverage~~
~~06 Crime victim~~
~~24 Date insurance denied~~
~~25 Date benefits terminated by primary payer~~
~~A3 Benefits exhausted, Payer A – Medicare~~
~~B3 Benefits exhausted, Payer B – Primary or other insurance~~
~~C3 Benefits exhausted, Payer C – Medicaid~~

~~All KMAP guidelines remain the same regarding attachments required for Third Party Liability (TPL) proof and SSA/Medicare EOMBs~~.

FL 39 Value Codes/Amount – Required if applicable

- Enter D3 for nonpatient obligation as the value code. Enter the nonpatient obligation dollar amount in the "Amount" field. Examples of nonpatient obligation are Parental, Spousal, and Trust.
- Enter 80 for covered days and enter the number of covered days in the Amount field.

Note: Count the date of admission but not the date of discharge..

FL 42 **Revenue Code – Required. Inpatient Only.** Enter the three-digit number code identifying the type of accommodation and ancillary service(s). **Do not indicate revenue code(s) if the service is noncovered.**
Note: Revenue codes are not to be indicated for outpatient services.
Use only the revenue codes listed below:
101 All inclusive room and board
180 NF/MH inpatient psychiatric hospital stay (21 day limit per hospital stay)
181 NF/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 days per stay)
189 Noncovered days

FL 45 **Serv. Date of Service – Required.** Enter the from date services were provided for the line item revenue code in MM/DD/CCYY format.

FL 46 **Service Units – Required.** Enter the number of days for each revenue code.

FL 47 **Total Charges – Required.** Enter the total charges. claim charge on the last line of the detail section. In FL 42, enter 001 for the revenue code, and in FL 47, enter the total charges.

FL 48 Non-Covered Charges. Not applicable to NF.

FL 50 **Payer Name – Required.** Enter all third party resources (TPR) liability (TPL).
Line A – Use to indicate primary insurance.
Line B – Use to indicate secondary insurance.
Line C – Use to indicate tertiary insurance.

Note: If primary payment was made by Medicare Part B, use Medicare Part B in Line A. Medicaid is always the last payer.

FL 51 Provider No. – Required. Enter your KMAP provider number on the appropriate line.

FL 54 Prior Payments – Required if other insurance is involved. Do not enter patient liability amount. It is deducted automatically during claims processing.
Line A – Use to indicate primary payment.
Line B – Use to indicate secondary payment.

~~Line C – Use to indicate tertiary payment.~~

FL 57 **Other Provider ID.** Enter the billing provider's taxonomy code or the KMAP provider ID. ~~**No Field Name – Desired.** Enter the original ICN if the current claim is beyond 12 months from the date of service.~~

~~*** Example**: Resident in facility for six days with the first date of service March 1, 2005:~~
~~Revenue Code (FL 42) equals 180~~
~~Service Date (FL 45) equals 03/01/05~~
~~Service Units (FL 46) equals 6~~

FL 60 **Patient ID Number.** ~~**Cert. – SSN - HIC - ID No. – Required.**~~ Enter the 11-digit beneficiary ID number from the beneficiary's medical ID card.

FL 61-62 **Group Name/Insurance Group Number. Required if KMAP is not the primary payer.** This information should correspond with payer data in FL 50.

FL 64 **Document Control Number.** Indicate the timely filing ICN, if applicable.

FL 67 **Primary Diagnosis Code** ~~**– Required.**~~ Enter the ICD-9-CM code to indicate the primary diagnosis. This must be a valid/active diagnosis code recognized by KMAP.

FL 67a-q **Other Diagnosis Codes.** Use these fields to provide additional diagnosis codes.

FL 74 **Principal Procedure – Required (if applicable).** Enter the ICD-9-CM procedure code for the primary procedure and date of service.

FL 74a-e **Other Procedure – Required (if applicable).** Enter other procedures performed, using ICD-9-CM procedure codes and date of service.

FL 76 **Attending Physician**

NPI – Enter the provider's national provider number.
QUAL – Not required.
ID – Enter your KMAP provider ID or taxonomy code in the space to the right of the word QUAL.
Last – Enter the provider's last name.
First – Enter the provider's first name.

FL 77 **Operating – Required (if applicable).**

FL 78-79 **Other – Required (if applicable).**

Note: If the claim is for a sterilization, the surgeon performing the sterilization procedure must be identified by their KMAP provider ID in field 78.

7020 Billing Instructions cont.
Updated 05/08

FL 80 **Remarks:** Specify additional information as necessary.

~~**FL 68-75 Other Diag. Codes – Required if applicable.** Enter the ICD-9-CM code to indicate additional diagnoses. These codes must be valid, active diagnosis codes recognized by KMAP.~~

~~**Fl 82 Attending Physician ID. – Optional**.~~
- ~~Attending physician's KMAP provider number~~
- ~~Attending physician's name~~

~~**FL 84 Remarks – Optional**. Specify additional information as necessary.~~

~~**FL 85 Provider Representative – Required.** Provider Signature.~~
~~Read statement on back of claim form, sign, and date.~~
~~Phrase "signature on file" or provider's name typed or stamped is acceptable.~~

~~**FL 86 Date – Desired.** Enter signature date.~~

Submission of Claim

Send completed claim and necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

7030 MS-2126 BILLING INSTRUCTIONS – See forms Appendix for a copy of the form Updated 05/08

Introduction to the Notification of Nursing Facility Admission/Discharge MS-2126

The completion of the MS-2126 (Notification of Nursing Facility Admission/Discharge) shall be completed by the provider and a copy sent to the local SRS office Economic and Employment Specialist (EES). 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.

Note: This form will need to be copied or duplicated by providers since neither the fiscal agent nor Kansas Health Policy Authority (KHPA) will furnish the form to providers.

When to Use the MS-2126

Sections I, II, and III, Facility Placement/Discharge, shall be initiated by the nursing facility when:

1. An eligible KMAP resident is initially admitted to or discharged from the nursing facility (NF), nursing facility for mental health (NF/MH), or intermediate care facility for mental retardation (ICF/MR).
2. A resident of an NF, NF/MH, or ICF/MR becomes eligible for Kansas Medical Assistance Program.
3. An eligible KMAP resident transfers from one facility to another facility.
4. A resident's eligibility has been reinstated after suspension for more than two months. (If two or fewer calendar months, a new form will be needed.)
5. An eligible KMAP resident is out of the facility for more than 30 days. (This is the same as a new admission.) When a resident returns to the facility on the 31st day, a new form will not be required. When a resident fails to return on the 31st day, a new form is required.
6. An eligible KMAP resident has a change in his/her level of care.

Section IV, Hospital Leave Information, shall be initiated by the facility to report any hospital admission and to report reserve days for a medical leave being claimed by the facility. **Completion of this section is not required for therapeutic (home) leave days**.

When a single hospital stay exceeds 30 days, the facility shall send another form to the local SRS office indicating the stay has exceeded 30 days and listing the estimated number of days the beneficiary will remain in the hospital.

Return to the Facility

Whether Section III or IV is being completed, the EES retains a copy of this form for their files. The original MS-2126, completed by the facility, and the Notice of Action must be retained by the nursing facility.

The facility shall notify the area/local SRS office of the resident's return date and submit a new form in accordance with the above instructions if required.

7030 Updated 05/08

How to Complete the MS-2126

Section I:

Name: Enter the resident's first name, middle initial, and last name as it appears on the medical identification (ID) card.

SSN: Enter the resident's Social Security number. If the resident does not have a Social Security number, enter "NA."

Date of Birth: Enter the resident's birth date in month, day, and year (MM/DD/CCYY) format. (Example: May 15, 1925 should appear as 05/15/1925.)

Sex: Indicate "M" for male and "F" for female.

Client ID Number: Enter the 11-digit resident number from the individual's KMAP card.

Responsible Person's Name: Enter the first and last name of the responsible party.

Responsible Person's Address: Enter the responsible person's street address, P.O. Box number, along with his/her city, state, and ZIP code.

Phone: Enter the responsible party's area code and telephone number.

Section II:

Facility Name: Enter the name under which the facility operates.

Provider Number: Enter your 10-digit KMAP provider number.

Address: Enter the street address, city, and ZIP code where the facility is located.

Date of Placement: Date resident was admitted to the facility.

Anticipated Length of Stay: Enter the number of months the resident is expected to be in the facility. If unknown, write "unknown."

Screened By: Enter the name of the person or facility completing the assessment. The State of Kansas requires that "each individual prior to admission to an NF receive assessment and referral services." To achieve this, the CARE program was created "for the data collection and individual assessment and referral to community-based services and appropriate placement in long-term care facilities.

7030 How to Complete the MS-2126 cont.
Updated 05/08

Date: Date screening was completed (if known).

Signature: The facility administrator or his/her designee signs here.

Phone: In the event there are questions, indicate the area code and telephone number to call.

Section III: Enter a check mark in the appropriate space to indicate (A) Admission, (B) Discharge, or (C) Deceased. Providers will also need to indicate the method of payment in place at the time of admission or discharge.

A1. **Admitted From**: Indicate where the resident is being admitted and the name of the facility they are coming from.

A2. Indicate method of payment at time of admission.

B1. **Discharged On:** Check the appropriate space to indicate where the resident is being discharged to, name of facility, and date of discharge.

B2. Indicate method of payment at time of discharge.

C. **Deceased Date**: Enter the resident's date of death.

Section IV:

A. Entered: Enter the name of the hospital and the date entered.

B. Reason Admitted: If known, indicate reason for admission. If unknown, write "UNKNOWN".

C. Estimated Days in Hospital: Indicate the number of days the admitting physician reasonably believes the resident will be in the hospital.

Reserve Day Notice: Once the facility has completed this form, it should be submitted to the local SRS office. ***Note:*** Since the information sent to the SRS office will not be returned, it is important for the facility to keep the original in their files.

Nursing Facility Processes Form

III. Facility Placement/Discharge: The facility is required to retain the completed form in the facility. These records shall be made available to SRS and/or the fiscal agent upon request. Absence of this form will result in suspension of payment to the facility.

IV. Hospital Leave Day Form: Retain the completed form in the beneficiary's records for documentation of medical reserve day approval.

7040 SPECIFIC BILLING INFORMATION
Updated 05/08

Denial of Payment/New Admission

When a nursing facility has been placed in Denial of Payment (DNP) status, the facility is not allowed to bill KMAP for new admissions. There may be a lapse of time between when the facility comes into compliance, and is removed from DNP status, and when KMAP receives the information the facility
is not in DNP status. Once the nursing facility is compliant, dates of service outside the DNP status may be submitted for payment.

Nursing facility residents are not to be considered new admissions in the following situations:

- When private pay residents of a nursing facility become Medicaid eligible, they are not to be considered a "new admit" if the facility is in Denial of Payment/New Admissions (DNPNA) status at the time the Medicaid eligibility becomes effective. The facility is to receive payment for residents who become Medicaid eligible during a Denial of Payment status.
- Nursing facility residents admitted before and discharged to a hospital with anticipated return on or after the date of the DNPNA are not considered new admissions if subsequently readmitted.
- Nursing facility residents who are admitted before the effective date of the DNPNA and take temporary leave are not considered new admissions when they return.

Note: The resident's status on the effective date of the denial of payment is the controlling factor in determining whether **readmitted** residents are subject to the denial of payment.

Duplicate Services

Only one nursing facility will be paid for the same beneficiary and the same date of service.

BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 08/08

KMAP beneficiaries will be assigned to one or more KMAP benefit plans. ~~The assigned plan or plans are listed on the beneficiary ID card.~~ 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 ~~contact the KMAP Customer Service Center at 1-800-933-6593 or (785) 274-5990~~.

8400. Medicaid Updated 08/08

The KMAP NF Program provides room, board, and all routine services and supplies required for residents in a NF. This program consists of NFs. NFs/MH and ICFs/MR are under Mental Health and Developmental Disabilities.

Nursing Facilities (NFs) are facilities that meet state licensure standards and provide health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-erm illness, disease, or injury.

Nursing Facilities for Mental Health (NFs/MH) are facilities that meet state licensure standards and provide health-related care and services, prescribed by a physician, in conjunction with recommended active treatment programming for residents with a diagnosis of mental illness or behavior disorders.

Intermediate Care Facilities for Mental Retardation (ICFs/MR) are facilities that meet state licensure standards and provide habilitation-related care and services, prescribed by a physician, in conjunction with active treatment programming for beneficiaries who are mentally retarded and who have related health and physical conditions.

Refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

~~**Coverage Indicator Codes** for NF residents appear under Item 9c) on the beneficiary's medical ID card (refer to Medicaid Eligibility in Section 2000 of the *General Benefits Provider Manual*). Coverage indicators are as follows:~~

- ~~**ACHS** – NF Resident State Rate Only~~
  - ~~State rate applies for clients with these indicators even in those rare instances when no Medicaid payment is made for the month.~~
- ~~**ACHD** – NF Resident/Payment Rate To Be Determined~~
  - ~~State rates are mandatory only for those months in which a Medicaid payment is made to the nursing facility. Facilities will be notified by the local SRS office on a case-by-case basis as changes in beneficiary eligibility for nursing facility payments occur.~~
- ~~**ACHN** – NF Resident/Payment Not Subject To State Participation (Resident failed the 300 percent income test, **no state payment**).~~

Any beneficiary with an **ACHN** indicator is not eligible for Medicaid payments for his or her NF services. **Do not submit claims to KMAP for these services**.

Charging a Medicaid Beneficiary (FR 483.12)

In the case of a person eligible for Medicaid, a NF must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be provided for the resident, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However, a NF may charge a resident who is eligible for Medicaid for supplies and services the resident has requested and received that are not part of what the state considers routine services and supplies included in the facility's per diem rate. The facility must give proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional noncovered services.

NF/MH Crisis Stabilization Placement:

Crisis stabilization placement is a useful alternative to state or general hospital psychiatric admissions. Crisis stabilization placement in a nursing facility for mental health (NF/MH) is covered after a preadmission assessment has been completed by a community mental health center (CMHC) and a determination made that the beneficiary meets the criteria for state or general hospital psychiatric admission that will be avoided through the crisis stabilization placement.

The CMHC must develop and retain in the beneficiary's medical record at the NF/MH a treatment plan for the crisis stabilization placement. Crisis stabilization placement must provide a more direct supervision and interaction with licensed staff members than in a nursing home setting. The staff to beneficiary ratio must not exceed 1:4. The staff must provide a safe, structured environment to assist the beneficiary in stabilizing and returning to a more normal environment. A maximum of 21 days is covered for crisis stabilization placement.

Mental Health Services for NF/MH Beneficiaries:

Mental health services to beneficiaries residing in a nursing facility for mental health are noncovered. Exception will be made for up to eight hours of therapy for individuals in acute trauma and for Targeted Case Management and Community Psychiatric Supportive Treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are psychiatric diagnostic interview, and psychiatric pre-admission assessments which require no special approval.

Home and Community Based Services (HCBS):

HCBS is an alternative care program in which Medicaid beneficiaries have the option to live more independently based on the community based screening team's assessment and subsequent recommendations. **Adult Day Health** and **Respite Care** are the only two HCBS services that may be provided by nursing facilities. The nursing facility must enroll as an HCBS provider. Contact the area/local SRS office for enrollment information.

Transportation:

The cost of transporting a current NF resident for nonemergent services (either by ambulance or commercial nonambulance medical transportation) is a responsibility of the nursing facility. This **includes new admissions** to the nursing facility. The home receives full payment for the date of admission; therefore, reimbursement for transportation is to be built into the facility's per diem rate. The cost of transporting residents and new admissions to the nursing facility is a cost nursing facilities will incur. These expenditures should be included in the provider's cost report.

Hospice Coverage in Nursing Facilities:

KMAP will reimburse room and board services for beneficiaries (Medicaid and Medicaid/Medicare eligible) who live in nursing facilities participating in KMAP. Reimbursement will be provided when a beneficiary elects the hospice benefit and the hospice and facility have a written agreement under which the hospice is responsible for the professional management of the beneficiary's hospice care and the facility agrees to provide room and board. The room and board component of hospice coverage is not covered by Medicare but will be covered by KMAP. Payment will be made to the hospice for room and board for those who have elected hospice coverage. No payment will be made to the nursing facility.

8400. Updated 05/08

Medical/Nonmedical Absence:

KMAP allows up to ten days per confinement for reservation of a bed when a NF, NF/MH, or ICF/MR beneficiary leaves the facility and is admitted to an acute care facility when conditions under the reserve day regulations are met.

KMAP allows up to 21 days per admission for reservation of a bed when an NF/MH resident leaves the facility and is admitted to one of the state mental hospitals, private psychiatric hospital, Prairie View Mental Health Center, or a psychiatric ward in an acute care hospital.

If a beneficiary is **not** admitted to a hospital but is there for **observation** purposes only, it is considered an approved NF day and **not** a hospital or therapeutic reserve day.

In the event of a **nonmedical** absence from a NF, the facility must report the absence to the local SRS office. The local SRS office does not require an MS-2126 form. A maximum of 18 home leave days for NFs and 21 days for NF/MH are allowed per calendar year. Additional days require prior authorization (PA). Refer to Section 4300 of the *General Special Requirements Manual* for PA requirements. The number of nonmedical reserve days is restricted to 21 days per year for ICF/MR residents.

KMAP will not reimburse for days a bed is held for a resident beyond the limits set forth above. KMAP will not reimburse for medical absences without prior approval on the MS-2126 form.

Regulatory Intent:

The intent of KAR 30-10-15a and 30-10-210 is to ensure consistency and clarification regarding which routine supplies nursing facilities are responsible to provide at no additional charge to the resident. Essentially, there is responsibility on the part of the provider as well as the beneficiary. Each provider must make available to all beneficiaries in their facility the routine services and supplies defined in KAR 30-10-15a for NFs and NFs/MH and KAR 30-10-210 for NFs/MH. The expense of these items is to be included in the cost reports and is reimbursed through the Medicaid rate. **Beneficiaries and beneficiaries' families are not to pay for routine supplies and services.**

Facility and Beneficiary Responsibility and Rights:

Federal regulations specify "the resident has the right to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health and safety of the individual or other residents would be endangered."

The facility is responsible to make reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered. The facility is not expected to stock all items carried by vendors in their community that are viewed as over-the-counter (OTC) products.

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Routine Services and Supplies for NFs, NFs/MH, and ICFs/MR:

The NF reimbursement rate includes, but is not limited to, the following durable medical equipment, medical supplies and other items and services as routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the comprehensive assessment and plan of care and shall not be billed or reimbursed separately from the per diem rate:

Alternating pressure pads and pumps
Analgesics (OTC)
Antacids (OTC)
Armboards
Bedpans, urinals, basins
Bedrails, beds & mattress and mattress covers
Blood glucose monitors and supplies
Canes
Commodes
Compressors
Crutches
Denture cups
Dialysis & maintenance
Dressing items (applicators, tongue blades, tape, gauze, bandages, bandaids, pads and compresses, elasticized ~~ace~~ bandages, petroleum jelly ~~vaseline~~ gauze, cotton balls, slings, triangle bandages, pressure pads, and tracheostomy care kits)
Emesis basins, bath basins
Enemas and enema equipment
Extra nursing care and supplies
Facial tissues & toilet paper
First aid type ointments
Footboards
Foot cradles
Gel pads or cushion (example: Action Cushion)
Geriatric ~~Geri-~~chairs
Gloves, rubber or plastic
Gradient compression stockings
Heating pads
Heat lamps, examination light
Humidifiers, concentrators and canisters, and stands
Ice bags, hot water bottles
Intermittent Positive Pressure Breathing (IPPB) machines
Irrigation solution (H2O, normal saline)
I.V. stands, clamps, and tubing
Laundry (including personal laundry)
Laxatives
Lifts
Lotions, creams and powders
Maintenance care for residents who have head injuries
Mouthwash
Nebulizers
Nutritional supplements
Orthotics and splints to prevent or correct contractures
Ostomy supplies
Oxygen, masks, stands, tubing, regulators, hoses, catheters, cannulas and humidifiers
Parenteral, enteral infusion pumps
Patient gowns, pajamas, bed linens
Restraints
Sheepskins, foam pads
Skin antiseptic
Sphygmomanometer, stethoscopes, & other examination equipment
Stool softeners
Stretchers
Suction pumps and tubing
Syringes & needles ~~(except insulin syringes & needles for diabetics that are covered by pharmacy program)~~
Therapy (occupational speech, physical, respiratory)
Thermometers
Total nutritional replacement therapy
Traction apparatus & equipment
Transportation (non-emergent)
Underpads & adult diapers (disposable/non-disp.)
Urinary supplies, urinary catheters and accessories
Vitamins (OTC)
Walkers
Water pitchers, glasses, straws
Weighing scales
Wheelchairs

8400 Updated 05/08

~~**DME/Medical Supply:**~~

~~These services must be billed through the DME or medical supply provider.~~

Legend Versus Nonlegend Drugs:

A **legend** drug is any medication which requires a prescription in order to be dispensed.

Nonlegend drugs are those items essential to the health, safety, and welfare of the residents that can be purchased over-the-counter.

Items the Facility May Charge the Beneficiary:

Legend drugs not covered by the KMAP pharmacy program may be billed to the beneficiary. Examples of noncovered legend drugs include some benzodiazepines (such as Librium®, Dalmane®, Centrax®, and Doral®), and cough and cold medications.

SRS allows beneficiaries to submit medically necessary charges for prescribed **legend drugs** and other noncovered services (such as dental services) to be used **to reduce their patient liability**. Currently, there is no provision for reimbursement to nursing facilities for dental services. Provisions for dental services are covered under K.A.R. 30-5-100 and 30-5-100a, and 30-50-159.

Nonlegend items are those over-the-counter products essential for the beneficiary to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

While it is true a physician can write a prescription to have some items dispensed by the pharmacy, the products of like nature can be purchased over-the-counter and included in the provider's cost report at a much lower cost without cost to the beneficiary.

Over-the-counter items are considered routine and the responsibility of the nursing facility to provide within the bounds of reasonable accommodation.

Stock Routine Items Provided by a Nursing Facility:

Medicaid uses the term "formulary" to include those items that are covered by the KMAP pharmacy program. As a suggestion to the facility operators, it might be helpful to establish an OTC formulary of products provided as part of the routine supply items and to communicate this information to residents, pharmacy, and physicians. This approach might help eliminate the confusion (and demand) for products not routinely stocked by the facility.

Nutritional Therapy:

Products used for the resident that are considered nutritional supplements should be included by the facility in their cost reports.

8400. Updated 05/08

~~Total nutritional replacement therapy is covered if prior authorization is received and billed through the durable medical equipment (DME) provider.~~

~~In either case, d~~Do not bill the resident for the nutritional supplements or replacements.

Over-The-Counter Items – Facility Responsibility or Paid By the Pharmacy Program:

Over-the-counter drugs/supplies and/or personal comfort items which are regularly available without prescription at a commercial pharmacy or medical supply outlet and which may be stocked by the facility are considered routine.

Depending on how physicians prescribe a particular medication, there are instances when an over-the-counter product may be either the responsibility of the nursing facility or paid for by the pharmacy program.

An example of this would be analgesics. Over-the-counter analgesics that are prescribed for occasional relief of pain/discomfort or PRN are the responsibility of the facility to pay for and stock. However, over-the-counter analgesics prescribed for an individual resident covered by KMAP may be billed to the pharmacy program if prescribed for a scheduled dosage regimen.

~~**Urinary Catheters and Accessories (KAR 30-10-15a(b)(2):**~~

~~Urinary catheters and accessories shall be covered services through KMAP when billed through the DME provider. This expense shall not be reimbursed in the per diem rate of the nursing facility cost report.~~

Ventilator-Dependent Residents:

The following are the policies and procedures for determining a rate for a ventilator-dependent resident in a nursing facility.

The request for additional reimbursement for a ventilator-dependent resident must be submitted to KHPA ~~Kansas Department of Social and Rehabilitation Services (SRS)~~ or the Kansas Department on Aging (KDOA) in writing for prior approval. Each request must include a current care plan for the resident, the most current Minimum Data Set (MDS) resident assessment and an itemized budget for implementing the care plan. ~~The itemized expenses shall not include the cost of durable medical equipment (DME) reimbursed in accordance with the DME program in the KMAP Manual.~~

All of the following criteria shall be present for a resident to be considered ventilator-dependent:

- The resident is unable to breathe without mechanical ventilation.
- The resident uses the ventilator for life support 24 hours a day, seven days a week.
- The resident has a tracheostomy or endotracheal tube.

The provider is reimbursed the KMAP daily rate determined for the nursing facility plus an additional per diem amount approved by KHPA ~~SRS~~ and KDOA for the ventilator-dependent resident. The additional reimbursement must be prior authorized by KHPA ~~SRS~~ and KDOA. The provider must submit a budget with the detail of the expenditures requested to care for the ventilator-dependent resident. The reimbursement shall be negotiated based on the prevailing cost of the individualized care plan and subject to an upper payment limit. The upper payment limit shall be the rate from the

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Medicare Prospective Payment System (PPS) for skilled nursing facilities as based on the MDS assessment and using the Resource Utilization Groups Version III (RUGs III) classification system. All 53 classifications in the RUGs III system will be used to determine the corresponding Medicare PPS per diem rate.

No additional amount above the current daily rate shall be allowed until the service is prior authorized by KHPA ~~SRS~~ and KDOA.

The criteria must be reviewed quarterly to determine if the resident continues to be ventilator-dependent. If a resident is no longer ventilator-dependent, the provider does not receive additional reimbursement beyond the KMAP per diem rate determined for the facility.

The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report.

The overall per diem rate for a ventilator-dependent resident must not exceed the lower of the prevailing cost for the individualized care plan or the Medicare PPS rate. The per diem rate increase for the ventilator-dependent resident will be added to the computed KMAP rate in effect for the nursing facility.

REQUIREMENTS

Advance Directives:

Nursing facility providers participating in KMAP must comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives. An "advance directive" is otherwise known as a living will or durable power of attorney. Every nursing facility provider must maintain written policies, procedures, and materials about advance directives.

Specific Requirements

1. Each nursing facility must provide written information to every adult individual receiving medical care by or through the nursing facility. This information must contain:
   - Individual's right to make decisions concerning his or her own medical care.
   - Individual's right to accept or refuse medical or surgical treatment.
   - Individual's right to make advanced directives.
   - Department of Social and Rehabilitation Services' "Description of the Law of Kansas Concerning Advance Directives." SRS does not provide copies of the description to providers. It is up to providers to reproduce the description.

   Providers are free to supplement this description as long as they do not misstate Kansas law.

2. Additionally, each nursing facility must provide written information to every adult individual about the nursing facility's policy on implementing these rights.

3. A nursing facility must document in every individual's medical record whether the individual has executed an advance directive.

4. A nursing facility may not place any conditions on healthcare or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.

5. Each nursing facility must comply with State law about advance directives.

6. Each nursing facility must provide for educating staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Incapacitated Individuals
An individual may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, or other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the nursing facility must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.

If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the hospital must note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive
When a patient, relative, surrogate or other concerned/related person presents a copy of the individual's advance directive to the nursing facility, the facility must comply with the terms of the advance directive to the extent allowed under State law. This includes recognizing powers of attorney.

Description of the Law of Kansas Concerning Advance Directives:
There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions".

The Kansas Natural Death Act, K.S.A. 65-28,106, et seq.
This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may take a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will." The declaration must be:

- In writing
- Signed by the adult making the declaration
- Dated
- Signed in front of two adult witnesses, or notarized

8400 Description of the Law of Kansas Concerning Advance Directives cont.
Updated 6/06

There are specific rules set out in the law about the signature in case of an adult who can't write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may **not** serve as witnesses. A declaration has no effect during pregnancy. The declaration may be revoked in three ways:

- By destroying the declaration.
- By signing and dating a written revocation.
- By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declarations.

The Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625, et seq.
A "durable power of attorney for health care decisions" is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The power of attorney applies to health care decisions even when the adult is not in a terminal condition. The adult may give the agent the power to:

- Consent or to refuse consent to medical treatment
- Make decisions about donating organs, autopsies, and disposition of the body
- Make arrangements for hospital, nursing home, or hospice care
- Hire or fire physicians and other health care professionals
- Sign releases and receive any information about the adult

A "durable power of attorney for health care decisions" may give the agent all of the powers or may choose only some of the powers. The power of attorney may **not** give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The power of attorney only takes effect when the adult is disabled unless the adult specifies that the power of attorney should take effect earlier.

The adult may **not** make a healthcare provider treating the adult the agent except in limited circumstances.

8400 The Kansas Durable Power of Attorney for Health Care Decisions Law cont.
Updated 12/06

The power of attorney may be made by two methods:

1. In writing
2. Signed by the adult making the declaration
3. Dated
4. Signed in front of two adult witnesses
   Or:
   Written and notarized

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may **not** serve as witnesses.

The adult, at the time the power of attorney is written, should specify how the power of attorney may be revoked.

The Patient Self-Determination Act, Section 1902(w) of the Social Security Act

This federal law, codified at 42 U.S.C. Sec. 1396a(w), applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about healthcare and to make advance directives.

This law also required each state to develop a written description of the State law about advance directives. This description was written by the Kansas Health Policy Authority to comply with that requirement. If you have any questions about your rights to decide about healthcare and to make advance directives, please consult with your physician or attorney.

Third Edition: January 14, 2003

Income Test Requirement:

~~Persons applying for long-term nursing facility care coverage (including mental retardation facilities and state institutions) must have a gross income which does not exceed 300 percent of the one-person SSI benefit level. This amount will increase annually in January due to cost of living adjustments. Also, they may not become eligible by spenddown method to qualify for nursing facility coverage. Those individuals whose income exceeds 300 percent of the one-person SSI benefit level will not be eligible for nursing facility coverage but may otherwise qualify for other Medicaid benefits. Individuals residing in nursing facilities and receiving medical assistance prior to July 1, 1992,~~
~~that are above the income test of 300 percent will continue to be eligible based on current rules.~~

For information regarding eligibility criteria including income, resources, and establishment of patient liability – please refer to the Kansas Economic and Employment Support annual at http://www.srskansas.org/KEESM/KEESM.htm

Inspection of Care (IOC) Reviews:

Inspection of Care (IOC) reviews are required for ICFs/MR and institutions for mental disease (psychiatric state hospitals). This process is performed by the Kansas Department on Aging.

Medicaid Credit Balances:

"Medicaid Credit Balances" are overpayments to the nursing facility for the care of Medicaid beneficiaries. A credit balance exists when the aggregate the facility receives for a given Medicaid beneficiary from all sources of payment is greater than that which is covered under the Medicaid State Plan. Sources of payment shall include, but are not limited to, payment received from the state, the beneficiary, or any other third party payor.

Methods of processing Medicaid credit balances may be handled in one of the following ways:

- Amounts overpaid by the beneficiary resulting in a credit balance may be refunded to the beneficiary or responsible party acting as payee
- Amounts overpaid by the state that result in a credit balance should be adjusted by the facility on the Adjustment Request Form
- Amounts paid by third party payers, such as an insurance company, should be applied to the facility's reimbursable amount. Since the facility should only be accepting the amount paid by the state and the beneficiary as payment in full, the facility may use the Adjustment Request Form to refund an overpaid amount due the state.

States are required to adjust any outstanding Medicaid credit balances within 60 days after notification by the nursing facility that a credit balance exists and cannot be corrected by the facility with an Adjustment Request Form, refund, or some other method. Where credit balances continue to exist, report this information in writing to the Nursing Facility Program Reimbursement Manager, Kansas Department on Aging, 503 S Kansas Ave, Topeka, KS 66603.

Personal Needs Funds (KAR 30-10-11 and 30-10-208):

In accordance with KAR 30-10-11 and 30-10-208, the NF, NF/MH, and ICF/MR must not require residents to deposit personal funds with the facility. If the facility accepts written authorization from the resident to manage and account for personal funds, it must deposit all amounts of $50 and over in an interest-bearing account separate from the facilities operating accounts and credit interest to the separate account(s). The facility may maintain personal funds of less than $50 in a noninterest bearing account or petty cash fund.

The facility must keep separate accounting for each resident's personal funds, including a written record of all financial transactions, and provide residents, or their legal representatives, with reasonable access to these records.

Upon a resident's death, the facility must promptly convey personal funds and a final accounting to the administrator of the resident's estate.

The facility may not charge personal funds for anything payable under Medicare or KMAP.

The facility must notify residents when their personal funds account reached $200 less than the resource eligibility guidelines. In addition, the notice must state that when the amount in the account exceeds that guideline, the resident may lose Medicaid eligibility.

Pre-admission Screening (KAR 30-10-2 [18]):

For PASARR compliance, the National Nursing Home Reform Law (PL-100-203) requires all Medicare, Medicaid, and private pay individuals be prescreened prior to admission to nursing facilities which are Medicaid certified to identify mental illness (MI), mental retardation (MR) and related conditions. The screening is designed to determine whether the individual is primarily in need of nursing care, medical care, or other services to treat the mental deficit or dysfunction.

Administration of the Kansas Preadmission Assessment Referral and Evaluation Program (KPARI) for Level I assessments is handled by CARE (Client Assessment, Referral, and Evaluation). Completion of the CARE assessment **prior** to nursing facility admission is required by law.

PASARR questions are incorporated as part of the form nursing facilities receive and should be included as a part of the individual's clinical record. The MS-2123 form is no longer a required form for facilities to complete.

In the event an individual is admitted to the nursing facility on an emergency basis, the responsibility of identifying individuals who appear to have an MI or MR condition lies with the nursing facility. The nursing facility is prohibited from admitting any resident who they believe has an MI or MR condition unless the state mental health or mental retardation authority has determined that the individual requires a nursing facility (NF) level of care.

Screening Evaluation and Referral (KAR 30-10-7):

Each individual seeking admission to a nursing facility or nursing facility for mental health providing care under Title XIX of the Federal Social Security Act, shall receive a preadmission assessment, evaluation, and referral to all available community resources, including nursing facilities **prior** to admission, with the following exceptions:

i. A patient who has entered an acute care facility from a nursing facility and is returning to a nursing facility
ii. Individuals whose length of stay is expected to be 30 days or less based on a physician's certification
iii. Individuals who are admitted to a nursing facility on an emergency basis based on a physician's certification to such an admission
iv. Individuals entering a nursing facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing
v. Individuals who have made written request for assessment and referral services from an authorized provider of assessment and who do not receive those services within 10 calendar day, if the assessment occurs within 20 days following admission

Kansas Administrative Regulation (KAR 30-10-7) allows a nursing facility that admits a KMAP eligible individual on an emergency basis to be reimbursed up to 13 days when the preadmission assessment determines the individual to be **inappropriate** for nursing facility level of care. Should this situation occur, the nursing facility will need to contact the Nursing Facility Program Reimbursement Manager at (785) 296-4986 for further instructions on how to submit a claim for reimbursement for the emergency admission allowed by the regulation.

Private Pay Wings (KAR 30-10-1f):

Kansas NFs cannot establish private pay wings or segregate Medicaid beneficiaries (KAR 30-10-1 f). The civil rights regulations prohibit discriminations based on race, color, national origin, sex, religion, and handicap. This policy assumes that all nursing facilities provide services to Medicaid residents
that meet Medicaid standards.

Resident Fund Surety Bond (KAR 30-10-11):

All Medicare/Medicaid certified facilities are required to have a Surety Bond to protect resident funds. Facilities are not required to use the "Resident Fund Surety Bond" form available from the Bureau of Adult and Child Care. The original completed Surety Bond form is to be sent to the Bureau of Adult and Child Care (Health and Environment). When the Surety Bond is amended, the original of the amended bond form must be submitted to the Bureau. An example of the Surety Bond Form available through the Kansas Department of Health and Environment is indicated at the end of the section. Organizations with more than one facility in Kansas may purchase one Surety Bond to cover their facilities. The bond cannot cover facilities outside the state of Kansas.

Submission of MDS Forms (KAR 30-10-2):

Nursing facilities and nursing facilities for mental health (NFs/MH) shall submit all completed MDS forms to the Kansas Department of Social and Rehabilitation Services. Forms must be submitted by electronic transfer. For questions concerning MDS submissions, contact the MDS Help Desk at 800-255-2309.

Failure to submit MDS forms in accordance with K.A.R. 30-10-2 will result in suspension of payments.

Time-Limited Agreements:

As a result of the Health Care Financing Administration (HCFA) ruling (HCFAR-92-1) and Section 1919 of the Social Security Act (the Act), agreements for nursing facilities (NFs) and nursing facilities for mental health (NFs/MH) are no longer time-limited. Therefore, provider agreements will not automatically expire.

Facilities must be in compliance with federal requirements as specified in Sections 1919(b), (c), and (d) of the Act. An on-site survey is required and is conducted periodically to verify compliance. Providers will be notified of any deficiencies cited as the result of a state/federal survey. When a deficiency is cited, an acceptable Plan of Correction must be submitted. Providers will also be notified of any adverse action initiated as the result of a finding of non-compliance with the regulatory requirements.

Transfer/Discharge Notice and Hearings:

Providers shall comply with all transfer/discharge notice requirement found in C.F.R. 483.12.

Facilities must provide the notice to the resident and, if known, a family member or legal representative of the resident must be notified of the proposed transfer or discharge. (42 C.F.R. Sec. 483.12(a)(4).) The nursing facility must list the date this notice is being delivered or mailed to establish the time the client may request an appeal. (42 C.F.R. Sec. 431.206(c)(2).) The notice must be made by the facility at least 30 days before the resident is transferred or discharged. (42 C.F.R. Sec. 483.12(a)(5).) The nursing facility must provide the specific federal regulation which supports the decision of the facility to transfer or discharge the resident. 42 C.F.R. Sec. 431.210(c); 42 C.F.R. Sec. 483.12(a)(2). The notice must list the effective date and the location to which the resident is to be transferred or discharged. 42 C.F.R. Sec. 483.12(a)(6).) The notice must contain specific information about the State Long-Term Care Ombudsman, and the protection and advocacy agency. (42 C.F.R. Sec. 483.12(a)(6).) **Most importantly, facilities must inform the resident of his/her right to appeal, the time and manner in which an appeal may be requested, who may represent him/her in the appeal, and the address to which the request must be made. (42 C.F.R. Sec. 483.12(a)(6)(iv).)**

Since the federal certification regulations or the Kansas Department on Aging licensing regulations may change from time to time, providers are responsible to ensure that the notice complies with the regulations in effect at the time the notice is sent.

"Notice of Right to Request a Hearing" **must** be prominently included in the notice to residents.

Failure to provide a proper notice may be grounds for termination of the KMAP provider agreement or subject the facility to sanctions by the Kansas Department of Health and Environment.

8400. Updated 05/08

ADDITIONAL SERVICES

~~**Oxygen (KAR 30-10-23a):**~~

~~Oxygen and allowable supplies provided in homes without central oxygen supply must be billed by the oxygen supplier.~~

~~Oxygen provided in homes with central oxygen supply must be billed by the nursing facility within 30 days after the completion of a calendar quarter. (Refer to Sections 7000 and 7020 of this manual for billing instructions.)~~

Private Room (KAR 30-10-15a[5]):

Private rooms for beneficiaries are covered when medically necessary or used at the discretion of the facility. The costs must be reflected in the facility's cost report. If a private room is not medically necessary or is not occupied at the discretion of the facility, a family member, guardian, conservator, or other third party may reimburse the difference between the usual and customary charge and the Medicaid payment rate.

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.

Information on how to bill Medicare for the flu vaccine and its administration can be obtained by calling the Medicare provider correspondence line at (785) 232-4994.

Hepatitis-B Vaccine for ICF/MR Residents:

Hepatitis B vaccine is available without charge to any KMAP beneficiary who resides in an intermediate care facility for mental retardation (ICF/MR) when the beneficiary's physician determines the beneficiary should receive the vaccine. The federal government will purchase vaccines from manufacturers and provide them without cost to physicians nationwide for Medicaid and other select groups of children.

KMAP vaccines are provided through the Vaccines for Children Program, including vaccines for Medicaid beneficiaries over the age of 18. The Kansas Department of Health and Environment (KDHE) administers the program. KDHE provides Hepatitis B vaccine to any physician enrolled as a provider in the Vaccines for Children (VFC) Program.

Requests for the Hepatitis B vaccine should be directed to physicians enrolled as VFC providers.

CHANGE OF OWNERSHIP

Nursing Facility: The Kansas Department of Aging (KDOA) will send enrollment packets to all nursing facilities when they are of a change of ownership. In certain instances, KDOA does not recognize these transactions as a change of provider, rather the change may be recognized as an ongoing entity for Medicaid purposes. Nonetheless, KDOA still needs a complete disclosure of information to make that determination. Providers not returning the enrollment packets to KDOA 30 days from the date sent will have their payments suspended. The person to contact at KDOA regarding your status is the Nursing Facility Program Reimbursement Manager at (785) 296-4986.

Nursing Facility for Mental Health: Social and Rehabilitation Services (SRS) will send enrollment packets to all nursing facilities for mental health when they are advised by of a change of ownership. In certain instances, SRS does not recognize these transactions as a change of provider, rather the change may be recognized as an ongoing entity for Medicaid purposes. Nonetheless, the agency still needs a complete disclosure of information in order to make that determination. Providers not returning the enrollment packets to SRS 30 days from the date sent will have their payments suspended. The person to contact at SRS regarding your status is the NF/MH Rate Coordinator at (785) 291-3202.

FORMS

CMS-1500

UB-04

MS-2126

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
							2
							3
							4
							5
							6
							7
							8
							9
							10
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							20
							21
							22
	PAGE ____ OF ____	CREATION DATE		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57	A
						OTHER	B
						PRV ID	C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
				A
				B
				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		A
		B
		C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

MS-2126
Rev 07-07

NOTIFICATION OF FACILITY ADMISSION/DISCHARGE

1. RESIDENT INFORMATION

Name: _____ SSN: _____ Sex: _____

Date of Birth: _____ Client ID #: _____

Responsible Person or Agency: _____ Relationship: _____

Responsible Person Address: _____

II. FACILITY INFORMATION

Facility Name/Location: _____ Phone: _____

Name of Agency/Person Placing Resident: _____ Facility Fax: _____

CARE or Screening Completed? Yes ☐ Date _____ No ☐ Reason: _____

Administrator's Signature (or Designee): _____ Date: _____

III. FACILITY PLACEMENT/DISCHARGE

A. ADMISSION 1. Admission Date: _____ Anticipated Length of Stay: _____

2. Admitted From (check one):

☐ NF ☐ ICF/MR ☐ NF/MH ☐ Hospital
☐ Private Home ☐ Swing Bed ☐ State Institution
☐ Assisted Living ☐ Other _____

If admitted from facility, name of facility: _____

3. Pay Status on Admission (check one): ☐ Private Pay ☐ Medicare or Private Insurance ☐ Medicaid ☐ Other _____

4. Current Level of Care in Your Facility:

☐ Nursing Facility (NF SN) ☐ NF - Mental Health (NF MH) ☐ State Hospital - MR (SH SD)
☐ Swing Bed (NF SB) ☐ Head Injury/Rehb. (NF HI) ☐ State Hospital - MH (SH SM)
☐ PRTF (BF MH) ☐ ICF/MR (NF SD)

B. DISCHARGE INFORMATION

1. Discharged to: (check one) 2. Discharge Date: _____ 3. Date Deceased: _____

☐ Private Home ☐ Facility ☐ Swing Bed ☐ Assisted Living
☐ Hospital ☐ Other _____

3. If discharged to facility or hospital, name of facility: _____ Level of Care: _____

IV. HOSPITAL LEAVE (Complete for absences over 30 days only):

Hospital: _____ Date Admitted: _____ Estimated: _____

This form must be filed with the local SRS office within five working days of the date of admission, discharge, death, or hospital leave. Distribution: Original to Facility; Copy to Local SRS Office.

MS-2126 Instructions

1. The facility initiates the MS-2126 under the conditions specified in KEESM 8184.1 within five days of the event/request. Specific conditions prompting an MS-2126 include:

- A medical recipient is admitted or discharged from the facility
- A resident files an application for medical assistance
- A resident has been absent from the facility for 30 days or longer
- A resident changes level of care

2. Sections I and II are always completed. Sections III or IV are completed as necessary.

3. If the resident is in SRS or JJA custody, note this in Section 1 under responsible person/agency. Contact the designated individual in the SRS Regional Service Center if additional information is needed.

4. For Psychiatric Rehabilitation Treatment Facility, follow processing guidelines outlined in the appropriate KMAP provider manual regarding prior authorization and prescreening.

5. Indicate the results of any required pre-admission screening. It is the responsibility of the admitting facility to ensure these requirements are met.

Note: A CARE assessment is NOT required for swing bed placements.

6. The facility shall retain the original MS-2126 and submit a copy to the SRS eligibility contact.

7. SRS will notify the facility when the MS-2126 is approved or denied. The facility will also be notified of the effective date and any applicable patient liability.