

**Kansas
Medical Assistance
Program**



2008 Spring Provider Workshops: Home and Community Based Services (HCBS)

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Benefit Plans And Eligibility

BENEFIT PLANS

Benefit Plans are printed on medical cards with the following values:

- ADAPD = AIDS Drug Assistance Program – Full Benefits
- TB = Tuberculosis
- TXIX = Title XIX
- MKN = MediKan
- QMB = Qualified Medicare Beneficiary

Values of Living Arr printed on the medical card are as follows:

- HCDD = HCBS Developmentally Disabled
- HCFE = HCBS Frail Elderly
- HCTBI (HI) = HCBS Traumatic Brain Injury
- HCPD = HCBS Physically Disabled
- HCSED = HCBS Severely Emotionally Disabled
- HCTA = HCBS Technology Assisted

A primary care provider (PCP) name and telephone appear as primary provider.

- HCK = HealthConnect
- HW19M = HealthWave 19 Medical

A provider name and phone number appear as Lock-In Provider(s):

- HSPC = Hospice
- LKN = Lock-In

No medical card will be printed for the following benefit plans:

- HW19H = HealthWave 19 Mental Health
- HW21D = HealthWave 21 Dental
- HW21H = HealthWave 21 Health
- HW21M = HealthWave 21 Medical
- LMB = Low-Income Medicare Beneficiary – Dual
- PACE = Program of All-Inclusive Care for the Elderly
- QWD = Qualified Disabled Working Individual – Stand Alone
- SOBRA = Sixth Omnibus Bill Reconciliation Act
- TXXI = Title XXI (MCO) or Title XXI

KMAP Beneficiary ID Card

Explanation of ID card Fields

STATE OF KANSAS
HEALTH INSURANCE CARD

EFFECTIVE (1)

PERSON COVERED (2)
ID# (3) DOB/GENDER (4)

BENEFIT PLAN (5)

LIVING ARR. (6) COPAY (7)

KBH EXAM (8) LAST (a) NEXT (b)
EYE EXAM (9) LAST GLASSES (10)

PRIMARY MEDICAL PROVIDER (11)

SUBSTANCE ABUSE (12)

MENTAL HEALTH (13)

LOCK-IN PROVIDER(S) (14)

DATA CONTAINED ON THIS CARD MAY HAVE CHANGED SINCE (15)

REMAINING SPENDDOWN = \$ (16)
TPL/HMO (17)

SEE REVERSE SIDE FOR BENEFICIARY SIGNATURE (18)

1. **EFFECTIVE:** Eligibility effective dates (MM/DD/CCYY – MM/DD/CCYY).
2. **PERSON COVERED:** Beneficiary's last name, first name, and middle initial.
3. **ID:** Beneficiary's ID number.
4. **DOB/GENDER:** Birth date (MM/DD/CCYY) and sex of the cardholder.
5. **BENEFIT PLAN:** Benefit plan in which the beneficiary is enrolled.
6. **LIVING ARR.:** Living arrangement and level of care code.
7. **COPAY:** Beneficiary's co-pay indicator.
8. **KBH EXAM:**
 - a. **LAST** – Date of the beneficiary's last KAN Be Healthy screening (MM/DD/CCYY).
 - b. **NEXT** – Date of the beneficiary's next KAN Be Healthy screening (MM/DD/CCYY).
9. **EYE EXAM:** Date of the beneficiary's last eye exam (MM/DD/CCYY).
10. **LAST GLASSES:** Date the beneficiary received eye glasses (MM/DD/CCYY), followed by a P (Partial) if applicable.

11. **PRIMARY PROVIDER:** Name and phone number of the primary care provider assigned to the beneficiary.
12. **Substance Abuse Provider:** Name and phone number of the Substance Abuse Provider.
13. **Mental Health Provider:** Name and phone number of the Mental Health Provider.
14. **LOCK-IN PROVIDER(S):** Name and phone number of the beneficiary's lock-in provider (if applicable).
15. **DATA CONTAINED ON THIS CARD MAY HAVE CHANGED SINCE:** Date the card was generated (MM/DD/CCYY).
16. **SPENDDOWN REMAINING AMOUNT:** Dollar amount of the beneficiary's remaining spenddown as of the date in field 14.
17. **TPL/HMO:** Name, policy number, type of coverage, and address of other insurance.
18. The color printed in this field indicates the beneficiary's benefit plan. The colors are as follows:
 - Blue – Assigned to a managed care provider
 - Red – QMB only
 - Purple – Medically needy
 - Tan – ADAP only
 - Green – Fee-for-service

BENEFICIARY ELIGIBILITY VERIFICATION

Kansas Medical Assistance Program

Admin Eligibility Help Account Mail-box Logout

Monday 5 March 2007 11:10 am

Beneficiary Eligibility Verification

Beneficiary ID Search

ID:

OR

SSN Search

SSN: AND/OR Date of Birth:

OR

Name Search

Last: First: Date of Birth:

From Date of Service: To Date of Service:

[Dental Services Profile](#)

After logging on to the secured Web site, click on the **Eligibility Verification** link.

- Enter one of the following:
 - Beneficiary's ID number in the **ID** field
 - or*
 - Beneficiary's Social Security number in the **SSN** field and the date of birth in the **Date of Birth** field
 - or*
 - Beneficiary's last name in the **Last** field, first name in the **First** field, and date of birth in the **Date of Birth** field, respectively
- Enter a date in the **From Date of Service** field, or click on the arrow to display a calendar and click on the appropriate date.
- Enter a date in the **To Date of Service** field, or click on the arrow to display a calendar and click on the appropriate date. *Note:* The from date of service and to date of service must be in the same calendar month.
- Click **Search**.

BENEFICIARY ELIGIBILITY VERIFICATION

Verification No. 0800804575 - 1/8/2008 - Status: A

Beneficiary

I.D.	Last Name	First Name	Middle Initial A
SSN	Medicare HIC	Sex	
Date of Birth	Date of Death		
Frames Paid Date	Lens Paid Date	Eye Exam Paid Date	
Psychological Testing	Psychotherapy	Remaining Spenddown Amount	

KBH

KBH Indicator	Y	Last Medical	05/08/2006	Next Medical	05/08/2008
Last Eye Date	12/06/2006	Last Hearing Date	05/08/2006	Last Dental Visit	08/14/2007

LTC

Therapeutic Days Used	Patient Liability/Client Obligation
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Eligibility

Benefit Plan	Effective	End
TITLE XIX (MEDICAID)	01/01/2008	01/31/2008
HealthWave 19 Medical	01/01/2008	01/31/2008
Prepaid Inpatient Health Plan	01/01/2008	01/31/2008
Prepaid Ambulatory Health Plan	01/01/2008	01/31/2008

NEMT

NEMT Level	Effective	End	Recertification Date
LEVEL1 - Ambulatory	01/01/2008	01/31/2008	

Managed Care Medical

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
,	No number listed.	UNICARE HEALTH PLAN	(866) 408-7105

Managed Care Substance Abuse

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
,	No number listed.	VALUEOPTIONS OF KANSAS INC	(866) 645-8216

Managed Care Mental Health

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
,	No number listed.	KANSAS HEALTH SOLUTIONS	(888) 547-2878

The eligibility information displays. Notice the **Status** refers to successfully completing the electronic transaction and not the beneficiary's eligibility. The dates of eligibility and benefit programs determine the beneficiary's overall coverage.

- Please note the section currently labeled LTC will be changing sometime this spring. It will now be called Living Arrangement. You will no longer have the sub heading Therapeutic Leave Days; this will be replaced with Level of Care. You will still be able to see the Patient Liability and Client Obligation in this location.

Explanation of Eligibility Verification

I.D. – The KMAP 11-digit beneficiary identification number.

Last Name – The beneficiary's last name.

First Name – The beneficiary's first name.

Middle Initial – The beneficiary's middle initial.

Sex – The beneficiary's gender.

Date of Birth – The beneficiary's date of birth (MM/DD/CCYY).

Remaining Spenddown Amount – The amount of spenddown the beneficiary has remaining.

Patient Liability/Client Obligation – The amount for which the beneficiary is responsible when residing in a nursing facility or receiving Home Community Based Services (HCBS). This information is assigned by SRS and is listed on the plan of care.

Benefit Plan – The description of the benefit plan in which the beneficiary is enrolled.

HCBS benefit plans cannot be assigned to the beneficiary as a stand-alone plan.

Therefore, in the Eligibility fields, you will see plans other than just the HCBS plans.

Different values of HCBS plans are HCBS-DD, HCBS-FE, HCBS-PD, HCBS-SED, HCBS-TA, and HCBS-TBI (HI).

Effective – The date the benefit plan went into effect (MM/DD/CCYY).

End – The date the benefit plan is scheduled to end (MM/DD/CCYY).

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Kansas Medical Assistance Program



Submission Options: Internet

SUBMISSION OPTIONS: INTERNET

<https://www.kmap-state-ks.us>

Services provided on the KMAP Web site are free of charge.

To use the Web site effectively, the following list of requirements must be met:

- **Internet Explorer 6.0 (or higher)**
 - If you do not have Internet Explorer, you can download it from the KMAP Web site.
- **Modem**
- **Phone line, DSL, or Cable connection**
- **Internet Service Provider (ISP)**
 - If you do not have an Internet Service Provider, you can contact the EDI help desk to become authorized to use our Remote Access System (RAS) to connect to the KMAP Web site free of charge. You may contact the EDI help desk by phone at 1-800-933-6593 and press 3#, or by e-mail at EDI.kmap@eds.com.

There are two main areas of the Web site: public and secure.

- Public Web site – Provides KMAP information and enrollment procedure to the general public.

The public Web site includes:

- Provider manuals
 - Provider bulletins
 - Enrollment forms
 - KAN Be Healthy information
 - EDI and PES information
 - Managed Care information
 - Provider directory
- Secure Web site – Provides a secure means for the MMIS and authorized users to access and exchange data. The secure Web site requires you to log on using a confidential ID and password.

The secured Web site includes:

- Switch provider number (clerks only)
- Claim submission
- Claim inquiry
- Copy claims for recurring services
- Beneficiary eligibility

With the interChange MMIS, providers can receive rapid decisions on the majority of their claims by using the secure KMAP Web site. Additionally, the claim forms on the KMAP Web site provide front-end editing to help reduce the possibility of errors when entering claims. These options are not available for paper claims.

What is the end result for providers?

Submitting your claims electronically or via the Web site assures you a faster response and a higher quality of data submitted!

All Internet transactions meet HIPAA compliance. All you need to do is protect your logon information and manage your staff's logon capabilities.

KMAP WEB SITE – HOME PAGE

Kansas
Medical Assistance
Program



[Home](#) [General](#) [Beneficiary](#) [Provider](#) [Managed Care](#) [KBH](#) [Publications](#) [EDI](#) [Contact Us](#)

Welcome to KMAP

Kansas Medical Assistance Program Web Site

The KMAP Web site provides health and medical policy information to beneficiaries and providers. Our vision is to connect Kansans with quality healthcare, regardless of their ability to pay.

[Beneficiary](#)

The Beneficiary section has information about the Kansas Medical Assistance Program. To get a more detailed listing of topics, click on the Beneficiary tab.

[Provider](#)

The Provider section has information geared toward potential or current contracted Medicaid providers. To get a more detailed listing of topics, click on the Provider tab.

[KAN Be Healthy](#)

The KAN Be Healthy section provides educational information to assist with program guidelines and regulations, as well as ways to increase program participation. To get a more detailed listing of topics, click on the KAN Be Healthy tab.

[NPI Information](#)

The NPI section has information for providers regarding KMAP's implementation of the National Provider Identifier.

Date Last Modified: November 30, 2007

Instructions for Users with Visual Disabilities

To request information on this Web site in an alternate format, please call
1-800-766-9012 (beneficiaries) or 1-800-933-6593 (providers).

DISCLAIMER

This Web site is provided as a convenience to providers and stakeholders of the Kansas Medical Assistance Program. Despite our best intentions to be complete and accurate, due to time lags, discrepancies may sometimes occur and materials on this site may not be consistent or up-to-date with current program guidelines. Normally, other forms of written communications may supersede the Web site materials. With this site, provider bulletins – or the most recently updated pages of this site – should prevail. If in doubt, contact the KMAP Customer Service Center at 1-800-766-9012 (beneficiaries) or 1-800-933-6593 (providers).

To LOG ON

Go to <https://www.kmap-state-ks.us> and click **Provider**.

On the Provider home page, click the MMIS Logon link at the bottom of the page.

Note: If you have never logged on or have forgotten your password, contact the KMAP Customer Service Center to obtain your user name and password. You can then enter this information in the Already a Member section and click **Log On**. This information is case sensitive and must be entered exactly as it was created.

The system will prompt you to change your password every 30 days for security purposes.

Your account will be locked out if you do not log on in 90 days or if you mistype your password three times. To reactivate your account, the contact person associated with the user name must call the KMAP Customer Service Center.

Kansas Medical Assistance Program

[KMAP Main](#) [Login](#) [Help](#) [Forgot Password?](#)

Wednesday 30 January 2008 09:06 am

Welcome to KMAP's Secure Web Site!

The Kansas Medical Assistance Program's (KMAP's) secure Web site is intended for providers, clerks and billing agents. Access to this site requires a personal identification number (PIN) for initial access or a user ID and password. For information on obtaining a PIN, please see [Information on obtaining PIN](#) below.

This site gives you the opportunity to view claim status inquiry, claim summary, prior authorization inquiry and claim payment summary. Also, you may receive messages from the Kansas Health Policy Authority (KHPA) that apply specifically to you. Whether you are [already a member](#) or a [first-time user](#), please enter the required information below to enter our secure Web site.

This Web site is compatible with Microsoft Internet Explorer version 5.0 and higher only. You may download Internet Explorer from the following location: 

Already a member?

Log on to KMAP's secure Web site.

User Name

Password

First time here?

If you have received a PIN letter, you may set up your account now.

Log On ID

PIN

Information for obtaining PIN?

If you have not completed an application, please select and complete an application from the [Provider Enrollment Applications](#) page that matches your practice or business.

If you have completed the application and have not received the PIN letter or lost the PIN letter, please call the KMAP Customer Service Center at 1-800-933-6593 between 7:30 a.m. and 5:30 p.m. Central Standard Time, Monday through Friday.

KMAP WEB SITE – PROVIDER MENU

Kansas Medical Assistance Program

Main Claims Eligibility Pricing Prior Auth. Trade Files Account Mail-box Help Logout

Wednesday 19 December 2007 09:40 am

Provider:

NPI:

Provider Agreement renewal: Required for all providers. Additional Information

- [Claim Submission](#)
- [Claim Inquiry](#)
- [Prior Authorization](#)
- [Eligibility Verification](#)
- [Provider Eligibility](#)
- [Pricing & Limitation](#) information for Procedures, Diagnosis, Drugs, and Revenue Codes
- [Workshop Schedule](#)
- [Rights to Appeal](#)
- [RA Banner Search](#)
- [Payment Inquiry](#)
- [DEA Inquiry](#)
- [NPI Capture](#)
- [NPI Search](#)

If you want to appeal any notice of denial, you may file a request for a fair hearing before an impartial hearing officer. To request a fair hearing, you must file a written request with the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, KS 66612 within 30 days of the written notice. If KHPA mailed this notice of denial to you, K.S.A. 77-531 allows you an additional three days to file such a request.

Your most recent Paper Remittance Advices:

Filename	Date Downloaded
Submit a request to receive remittance advices online.	

The main Provider menu appears after you log on and view your global messages. From here, you can click any of the links on the window to access the corresponding pages.

The first option, Switch Provider Number, only appears if your clerk ID is associated with more than one provider number. This link gives you the ability to switch between provider numbers. If you use more than one provider number, it is very important to validate which provider number you are working under when submitting claims. Submitting claims under the wrong provider number could result in denied claims.

KMAP WEB SITE – CLAIM SUBMISSION

Kansas
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Program

[Main](#) [Claims](#) [Eligibility](#) [Pricing](#) [Prior Auth.](#) [Trade Files](#) [Account](#) [Mail-box](#) [Help](#) [Logout](#)



Tuesday 6 March 2007 12:50 pm

Claims

- [Dental](#)
- [Institutional](#) (for Inpatient, Outpatient, Long Term Care, Home Health, and Medicare Cross-over)
- [Professional](#)
- [Pharmacy](#)
- [Inquiry](#)
- [Right to Appeal](#)

By choosing Claim Submission, you will be able to choose the Professional claim type. Click **Professional** to access the Professional claim form.



Wednesday 26 December 2007 12:35 pm

Professional Claim

Billing Information Previous ICN <input type="text" value="60"/> Timely Filing Override ICN <input type="text"/> Provider Number <input type="text"/> <input type="text"/> NPI <input type="text"/> Beneficiary ID <input type="text"/> Last Name <input type="text"/> First Name <input type="text"/> <input type="text"/> Date of Birth <input type="text"/> Patient Account # <input type="text"/> Signature on File? <input type="text"/>		Service Information From Date <input type="text"/> Thru Date <input type="text"/> POS <input type="text"/> Accident Related Cause(s) 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> Accident Date <input type="text"/> Add Diagnosis <input type="text" value="Principle"/> <input type="text"/> Hospitalization Dates Related to Current Service From <input type="text"/> To <input type="text"/>		Charges Total Charges <input type="text" value="0.00"/> TPL Amount <input type="text" value="0.00"/> Carrier Denied <input type="text" value="No"/> Co-Pay Amount <input type="text" value="0.00"/> Crossover Medicare Paid Date <input type="text"/> Co-Insurance <input type="text" value="0.00"/> Deductible <input type="text" value="0.00"/> Allowed Amt <input type="text" value="0.00"/> Paid Amt <input type="text" value="0.00"/>	
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Referring Physician ↕

TPL ↕

Detail ↕

Item	Procedure	Units	Charges	Status	Allowed Amount	
1		0.00	0.00		0.00	<input type="button" value="Add"/> <input type="button" value="Remove"/>

Detail Information

Item From DOS To DOS

POS

Procedure Modifiers

NDC Information

	NDC	Unit of Measure	Quantity	Unit Price
x 1	<input type="text"/>	<input type="text"/>	0.000	0.00

Diag. Cross-Ref Units Charges

EPSDT/Family Planning

Rendering Physician

Rendering Physician NPI Taxonomy Code

Rendering Physician Last Name/Org Name First Name MI

Status Allowed Amount Co-Pay Amount

EPSDT Referral

Hard-Copy Attachments ↕

Billing Information

Billing Information

- **Previous ICN:** Do not use.
- **Timely Filing Override ICN:** Enter the internal control number (ICN) of the original claim to document timely filing for claims 12 months past the date of service. This field is not required but could result in claims with a date of service older than 12 months to deny for timely filing if this field is not completed. When entering a timely filing ICN, the ICN on the previously submitted claim must match on billing provider ID, beneficiary ID, and date of service; otherwise the claim will deny for timely filing. Please be sure you are entering the correct timely filing override ICN accordingly.
- **Provider ID:** This field auto-populates based on the user. This provider number will be considered the billing provider number.
- **NPI:** This field auto-populates based on the user. This NPI will be considered the billing provider number. This is not required for most HCBS providers.
- **Beneficiary ID:** Enter the KMAP beneficiary ID number. This field auto-populates the name and date of birth.
- **Last Name:** This field auto-populates based on the beneficiary ID you enter.
- **First Name:** This field auto-populates based on the beneficiary ID you enter.
- **Date of Birth:** This field auto-populates based on the beneficiary ID you enter.
- **Patient Account #:** Optional – Enter the beneficiary’s account number with your facility.
- **Referring Phys:** Enter the referring physician’s nine-digit base ID followed by the alphabetic service location. As of July 1, 2005, this field is not required.
- **Signature on File:** Enter Yes if the provider’s signature is on file.

The screenshot shows a web form titled "Billing Information". The fields and their values are as follows:

Field	Value
Previous ICN	60
Timely Filing Override ICN	
Provider Number	100453760 A
NPI	3146050310
Beneficiary ID	
Last Name	
First Name	
Date of Birth	
Patient Account #	
Signature on File?	▼

For quicker navigation through the claim form, use your **TAB** key.

Service Information and Charges

Service Information

- **From Date:** This field auto-populates based on the information entered in the detail portion of the claim.
- **Thru Date:** This field auto-populates based on the information entered in the detail portion of the claim.
- **POS:** Choose the appropriate place of service value from the drop-down box.
- **Accident Related Cause(s) 1, 2, 3:** Choose the appropriate primary, secondary, or tertiary accident related causes from the drop-down box.
- **Accident Date:** Enter the date corresponding to any values indicated in the Accident Related Cause(s). *Note:* This field is required if an Accident Related Cause value is indicated in fields 1, 2, or 3.
- **Diagnosis:** Enter the appropriate diagnosis code without decimals. Click the word Add to insert a new line if you need to enter multiple diagnosis codes. **DO NOT use decimals when reporting diagnosis.** When more than one diagnosis code is entered, a scroll bar appears to the right of the diagnosis code values. You may use the scroll bar to see all diagnosis codes entered.
- **Hospitalization Dates Related to Current Service:** Enter the date on which the beneficiary was admitted to an inpatient hospital.

The screenshot shows the 'Service Information' form. It includes fields for 'From Date', 'Thru Date', 'POS' (a dropdown menu), and 'Accident Related Cause(s)' with three numbered rows (1, 2, 3), each having a dropdown menu. Below these is an 'Accident Date' field and an 'Add Diagnosis' section with a dropdown menu set to 'Principle' and an empty text box. At the bottom, there is a section titled 'Hospitalization Dates Related to Current Service' with 'From' and 'To' date fields.

Charges

Total Charges: You cannot enter this field. The total charges are calculated by the charges entered on each detail line.

- **TPL Amount:** Enter the amount previously paid by the beneficiary's other insurance, if applicable.
- **Carrier Denied:** If another insurance was billed and it denied, select Yes from the drop-down box. Otherwise, leave as No.
- **Co-Pay Amount:** You cannot enter this field. This file populates after the claim processes.

The screenshot shows the 'Charges' form. It includes fields for 'Total Charges' (0.00), 'TPL Amount' (0.00), 'Carrier Denied' (a dropdown menu set to 'No'), and 'Co-Pay Amount' (0.00).

Detail

Detail

- **Item:** This field auto-populates.
- **From DOS (Date of Service):** Enter the from date of service.
- **To DOS:** Enter the to date of service.
- **POS (Place of Service):** Select the appropriate place of service from the drop-down box.
- **Procedure:** Enter the appropriate procedure code.
- **Modifiers:** Enter any modifiers for the procedure code. You can enter up to four modifiers.
- **NDC Information:** To be used if you are billing a HCPCS code that requires an NDC. Please see the most recent professional bulletin addressing this topic, bulletin 6132d.
- **Diag. Cross-Ref:** Enter the diagnosis reference indicator. For instance, if the principle diagnosis code applies to this detail line, enter 1. If the secondary diagnosis in the list of diagnoses you entered in the Diagnosis field under Service Location applies to the detail line, enter 2.
- **Units:** Enter the total number of units.
- **Charges:** Enter the charge amount corresponding to the service you are billing for this particular detail.
- **EPSDT/Family Planning:** Choose an appropriate value from the drop-down box.
- **Rendering Physician:** Enter the performing physician's KMAP provider number. If the rendering provider number is the same as the billing provider number, you can double-click in the field, or leave it blank and it will auto-populate.
- **EPSDT Referral:** Choose the appropriate referral value for the claim if applicable.
- **Add and Remove Buttons:** Use to add or remove detail lines as needed.

Reminder: Do not forget to click **Submit** when you have completed the claim.
This step is required to submit your claim.

KMAP WEB SITE – CLAIM INQUIRY

Kansas
Medical Assistance
Program



[Main](#) [Claims](#) [Eligibility](#) [Pricing](#) [Prior Auth.](#) [Trade Files](#) [Account](#) [Mail-box](#) [Help](#) [Logout](#)

Tuesday 6 March 2007 2:26 pm

Claim Inquiry

Provider: 123456789A

NPI:

Criteria

Beneficiary ID Claim Status

Patient Acct. # Date Type: Date of Service Warrant Date

ICN From Date Thru Date

ICN	Beneficiary ID	Patient Acct. #	From Date	Thru Date	Warrant Date	Billed Amount	Warrant Amount	Status
2006339005219			20061128	20061128	20061214	152.00	0	Denied
2006339005223			20061128	20061128	20061214	57.00	6.30	Paid
2006356026001			20061128	20061128	20070104	65.00	0.00	Paid
2006352001317			20061128	20061128	20061228	202.00	37.58	Paid
2006342002466			20061128	20061128	20061214	202.00	37.58	Paid
2006342002479			20061128	20061128	20061214	1072.00	73.65	Paid
2006355006729			20061128	20061128	20061228	80.00	12.29	Paid
2007002012688			20061128	20061128	20070111	202.00	0.00	Paid
2007005002393			20061128	20061128	20070111	202.00	37.58	Paid
2007005027244			20061128	20061128	20070111	1127.00	0.00	Paid
2007005027251			20061128	20061128	20070111	1635.00	0.00	Paid
6007053004955			20061128	20061128	20070301	109.00	2.32	Paid

[Previous](#)

[Next](#)

Claim Inquiry

1. Click **Claim Inquiry**.
2. If known, enter the beneficiary ID number in the **Beneficiary ID** field.
3. Select the appropriate **Claim Status** from the drop-down box: Any Status, Denied, Paid, or Suspended.
4. If the patient account number is known, enter it in the **Patient Acct. #** field.
5. Click the appropriate **Date Type** button.
6. If known, enter the internal control number in the **ICN** field.
7. Enter the from date of service in the **From Date** field and the through date of service in the **Thru Date** field.
8. Click **Search**.
9. To open the Internet claim, click the **Internal Control Number**. The claim details display in a separate window.

Resubmit Claim – Denied Claims Only

1. Access the denied claims from the **Claim Inquiry** window using the Claim Status field.
2. Once you identify the denied claim to correct, open the claim by single clicking on the corresponding ICN link.
3. The claim will display and allow you to change the information as needed.
4. Once you have entered the correct information, **TAB** to exit the corrected field and click **Re-Submit**.

Adjust Claim – Paid Claims Only

1. Access the paid claims from the **Claim Inquiry** window using the Claim Status field.
2. Once you identify the paid claim to adjust, open the claim by clicking on the corresponding ICN link.
3. Make any corrections, **TAB** to exit the corrected field, and click **Adjust**.

You cannot adjust a previously adjusted claim.

You cannot adjust a claim that is more than 24 months old.

Note: If the claim cannot be adjusted using the Web site, a paper adjustment form is required. See the *General Billing Manual*, Section 5600 for information regarding filing a paper adjustment.

Void Claim – Paid Claims Only

1. Access the paid claims from the **Claim Inquiry** window using the Claim Status field.
2. Once you identify the paid claim to void, open the claim by clicking on the corresponding ICN link. The corresponding claim will display.
3. Scroll to the bottom of the claim and click **Void**.

A new window appears stating the void was completed. This action creates an account receivable for the amount previously paid. The account receivable will be deducted from a future warrant.

Copy Claim – Paid Claims Only (Very Useful Tool for Recurring Billing)

1. Access the paid claims from the **Claim Inquiry** window using the Claim Status field.
2. Once you identify the paid claim to copy, open the claim by clicking once on the corresponding ICN link. The corresponding claim will display.
3. Scroll to the bottom of the claim and click **Copy Claim**. A new window will appear with an exact copy of the previously paid claim's data.
4. Make any changes to the copied version of the claim and click **Re-Submit**.

Note: It is important to verify whether you are adjusting an existing claim or copying a previously paid claim to submit as a new claim. Adjusting previously paid claims may result in KMAP taking back money.

PA Status Inquiry

Kansas
Medical Assistance
Program



[Main](#) [Claims](#) [Eligibility](#) [Pricing](#) [Prior Auth](#) [Trade Files](#) [Account](#) [Mail-box](#) [Help](#) [Logout](#)

Tuesday 6 March 2007 3:00 pm

Prior Authorization Inquiry

PA Number or Beneficiary ID and Assignment Code NDC Start Date

PA Number	Beneficiary ID	Assignment Code	Service Provider
<u>123456789012</u>	0010000000	HCBS - Pd	123456789


When searching for a prior authorization (PA) status, enter the information and click **Search**. When the results are returned, click the **PA Number** to display the Provider PA Inquire window.


If you do not have the PA Number, enter the Beneficiary ID and the Assignment Code. The NDC and Start Date fields are optional search fields for more specific data.

Provider PA Inquire

The Provider PA Inquire window displays the status of your PA request.

**Kansas
Medical Assistance
Program**





Main Claims Eligibility Pricing Prior Auth. Trade Files Account Mail-box Help Logout

Tuesday 6 March 2007 3:13 pm

Provider PA Inquire

Header

PA Number	123456789012	Beneficiary ID	00100000000	Date of Birth	03/12/1919
Last Name	MOUSE	First Name	MICKEY	Middle Initial	E
Provider	<input type="text" value="A"/>	Diagnosis	<input type="text"/>		
PCCM	<input type="text"/>	Assignment Code	HCBS - Pd		

Line Items

Status	Procedure	NDC	Revenue Code	Diagnostic Code
Approved	S5161			

Line Item

Status	<input type="text" value="Approved"/>		Service Type Code	<input type="text" value="Procedure Code"/>	
Procedure	<input type="text"/>	Procedure Thru	<input type="text"/>	Modifiers	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Effective Date	End Date	Units	Dollars	
Requested	<input type="text" value="01/01/2007"/>	<input type="text" value="01/31/2007"/>	<input type="text" value="1.00"/>	<input type="text" value="0.00"/>	
Authorized	<input type="text" value="01/01/2007"/>	<input type="text" value="01/31/2007"/>	<input type="text" value="1.00"/>	<input type="text" value="0.00"/>	
Used			<input type="text" value="0"/>	<input type="text" value="0"/>	
Servicing Provider	<input type="text" value="A"/>				
Tooth	<input type="text"/>		Tooth Quad	<input type="text"/>	

Reason Codes

Reason Code	Date Sent

Submission Options:

Provider Electronic Solutions (PES)

Provider Electronic Solutions

Provider Electronic Solutions (PES) is proprietary Microsoft Windows-based software that enables providers to submit claims electronically, receive claim status, and verify member eligibility in a batch mode. PES has an easy-to-use online help tool that can be activated at the individual field level or from a list of topics. Features, such as reference lists, archiving, and searches save valuable time by providing access to commonly used data. This eliminates re-entry of certain data. With built-in data validation and editing, providers prevent common data entry errors. Providers can also retrieve, resubmit, and print claims stored locally. The results are improved percentages of claims paid on the first submission.

PES is:

- *Free*
- *Easy*
- *Fast*
- *Proactive*

System Requirements (minimum):

- Pentium II with CD-ROM
- Windows 98/2000/XP
- MS Internet Explorer 5.5 or greater
- 64Mb RAM
- 800 x 600 resolution
- 100Mb hard drive space available
- 28.8 kbps modem (or faster)
- Printer with 8 pt MS Sans Serif font (optional)

PES may be installed on a hard disk or a network drive and may be installed on as many PCs as necessary. PES can also be installed for use by multiple computers in a network environment. Contact the network administrator to set up a shared database location for network installations.

To obtain your copy of PES, contact the EDI help desk at EDI.kmap@eds.com or 1-800-933-6593, option 3#. You may also download a copy from the KMAP Web site at <https://www.kmap-state-ks.us> (select EDI from the menu bar).

Submission Options: Paper

SUBMISSION OPTIONS: PAPER

Paper claims may be submitted to the following address:

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

** It is a rare occasion a HCBS provider will use a paper claim. Some reasons an HCBS provider might want to use a paper claims would be:

- Timely filing
- Claim with attachments

With the interChange MMIS, providers can receive rapid decisions on the majority of their claims by using the secure KMAP Web site. Additionally, the claim forms on the KMAP Web site provide front-end editing to help reduce the possibility of errors when entering claims. These options are not available for paper claims.

What is the end result for providers?

Submitting your claims electronically or via the Web site assures you a faster response and a higher quality of data submitted!

Visit the KMAP Web site at <https://www.kmap-state-ks.us>.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>	1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
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 _____	
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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
19. RESERVED FOR LOCAL USE	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____
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) E. DIAGNOSIS POINTER	F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>
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. NPI _____
	28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____ 33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. NPI _____

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CMS 1500 FIELDS

- Field 1** Check the Medicaid box.
- Field 1 a** *Insured's ID Number:* Enter the beneficiary's 11-digit KMAP ID number. No other number will be accepted in this field.
- Field 2** *Patient name:* Enter beneficiary's name.
- Field 3** *Birth Date:* Enter the beneficiary's date of birth.
Sex: Enter the beneficiary's gender.
- Field 5** *Patient Address:* Enter the beneficiary's street address.
- Field 9 a - d** *Other Insured's Name:* Required when there is secondary or supplemental insurance. Medicaid is the payer of last resort. There should not be coverage secondary to Medicaid. Exceptions to this are very rare. Since Medicaid is the payer of last resort, this field is blank. **Do not enter any data in these fields.**
- Field 10 a - c** *Accident Field:* Required when billing for accident related services. If a claim is accident related, check the appropriate boxes.
- Field 11 a - d** *Insured's Policy Group or FECA Number:* Required if there is insurance (other than Medicare) primary to Medicaid. Do not enter Medicare information in these fields. **If the beneficiary does not have primary insurance or if Medicare is the beneficiary's primary insurance, these fields need to be left completely blank.**
- Field 14** *Date of Current:* Required when billing for accident related services.
- Field 17** *Referring Physician:* Name of the referring physician (**not required on or after date of service July 1, 2005**).
- Field 17 a** *Referring Physician ID Number:* The referring physician's 10-digit KMAP provider number. No other number is accepted in this field (**not required on or after date of service July 1, 2005**).
- Field 18** *Hospitalization Dates:* Required if the services being billed on the claim are related to a hospital admission. If so, enter the date of admission and discharge.

- Field 19** *Reserved for Local Use:* Enter additional information that is needed to justify the billed service, such as chronic cough for a chest X-ray. This field is optional.
- Field 20** *Outside Lab:* Required if lab charges are being billed. Check the appropriate box.
- Field 21** *Diagnosis:* Enter the appropriate ICD-9 diagnosis code. Not all ICD-9 codes are valid for KMAP. Do not enter text in this field. Enter the codes only, no description. Numeric values only.
- Field 22 a** *Medicaid Resubmission Code:* Required if the claim is a resubmission. Enter the original internal control number (ICN) for this claim. This field is for timely filing purposes.
- Field 24 a** *Date(s) of Service:* Enter the date of service in MM/DD/YY format.
- Field 24 b** *Place of Service:* Enter the appropriate place of service code.
- Field 24 d** *Procedures, Services, or Supplies:* Enter the HCPCS five-digit base procedure code and appropriate modifiers. KMAP does not accept all modifiers. Numeric values only.
- Field 24 e** *Diagnosis Pointer:* Enter the line number from field 21 that applies to the charges on that line.
- Field 24 f** *Charges:* Enter your usual and customary charge for each service.
- Field 24 g** *Days or Units:* Enter the number of days, visits, or units that are applicable to this line.
- Field 24 j** *Rendering Provider ID. # :* Enter the performing provider's 10-digit KMAP provider ID. Field 24 j must be entered for every line being billed.
- In the upper shaded box, enter the performing provider's KMAP provider ID.
 - In the lower unshaded box, enter the performing provider's NPI.
 - Prior to processing date May 23, 2007, submit paper claims with the KMAP ID only or the KMAP ID and the NPI. Claims cannot be submitted with only the NPI prior to May 23, 2007. After May 23, 2007, claims can be submitted with the KMAP ID and/or the NPI.

- Field 28** *Total Charge:* Enter the total of all charges. If a claim has multiple pages, each claim must be totaled.
- Field 29** *Amount Paid:* Private insurance payments only. Do not enter write-off amounts, Medicare payment information, co-pay, client obligation, or spenddown information in this field.
- Field 30** *Balance Due:* Enter the balance due – the difference between the total charge and amount paid.
- Field 31** *Signature of Physician or Supplier:* Signature on file or stamp is acceptable. Make sure the signature is dated.
- Field 32** *Name and Address of the Facility Where Services Were Rendered:* This field is only required if the place of service is other than the provider's office or the patient's home.
- Field 33** *Physician's, supplier's Billing Name, Address, Zip Code, & Phone #:* If services are being billed under a group provider number, enter the group information. If services are being billed under an individual provider, enter the individual's information. The information in box 33 needs to match your KMAP provider file. **If you have questions regarding your provider file, please contact provider Enrollment.**
- Field 33a** Enter the billing provider's NPI.
- Field 33b** Enter the billing provider's KMAP provider ID.
- Prior to processing date May 23, 2007, submit paper claims with the KMAP ID only or the KMAP ID and the NPI. Claims cannot be submitted with the NPI only prior to May 23, 2007. After May 23, 2007, claims can be submitted with the KMAP ID and/or the NPI.



Kansas Medical Assistance Program



HCBS Procedure Codes

HCBS PROCEDURE CODES

Beginning January 1, 2004, certain local HCBS Procedure Codes and Diagnosis Codes can no longer be billed to the Kansas Medical Assistance Program. Diagnosis codes will always be 780.99. When billing via PES or the Internet, do not include the decimal point (for example, type 78099 instead of 780.99). Please see below for a list of new HCBS Procedure Codes, broken down by waiver, along with units billable.

<u>Waiver/Definition</u>	<u>Procedure Code (Modifier)</u>	<u>Units</u>
<i>Frail Elderly</i>		
Adult Day Care (Day Care Services)	S5101	1 unit = 1 to 5 hours. No more than 2 units can be billed in 24 hours.
Assistive Technology	T2029	1 unit = 1 purchase
Attendant Care Self Directed	S5125 (UD)	1 unit = 15 minutes
Attendant Care Provider Directed Level I (Homemaker)	S5130	1 unit = 15 minutes
Attendant Care Provider Directed Level II	S5125	1 unit = 15 minutes
Nursing Evaluation Visit	T1001	1 unit = 1 face-to-face visit per beneficiary per provider
Medication Reminder Service (Add-On with Personal Emergency Response)	S5185	1 unit = 1 month
Personal Emergency Response	S5161	1 unit = 1 month
Personal Emergency Response Installation	S5160	1 unit = per lifetime
Sleep Cycle Support	T2025	1 unit = 6 – 12 hours 1 unit allowed in a 24 hour time period
Targeted Case Management	T1017	1 unit = 15 minutes 800 maximum allowable units per calendar year
Wellness Monitoring	S5190	1 unit = 1 face-to-face visit every 55 days
<i>Traumatic Brain Injury (TBI/Hi)</i>		
Assistive Services	S5165	1 unit = 1 purchase
Behavioral Therapy	H0004	1 unit = 15 minutes (limited to 3744 units per consumer per calendar year – for any combination of the following HCBS/TBI (HI) therapies: Behavioral, Cognitive, Occupational, Drug/Alcohol, Occupational, physical and speech/language)
Cognitive Therapy	97532	1 unit = 15 minutes
Drug/Alcohol Therapy	T1012	1 unit = 15 minutes

Occupational Therapy	G0152	1 unit = 15 minutes
Personal Emergency Response Install	S5160	1 unit = up to twice per calendar year
Personal Emergency Response	S5161	1 unit = 1 month
Personal Services	S5126 (UC)	1 unit = 1 month
Physical Therapy	G0151	1 unit = 15 minutes
Sleep Cycle Support	T2025	1 unit = 8 hours in any given 24 hour time period
Speech-Language Therapy	G0153	1 unit = 15 minutes
Targeted Case Management	T1017	1 unit = 15 minutes – Max of 160 hour per individual per calendar year.
Transitional Living Skills	H2014	1 unit = 15 minutes (Max of 16 units per day and Max of 3120 units per calendar year per consumer)

Developmentally Disabled

Communication Devices	T2028	1 unit = 1 service (Beneficiary must be 18 years of age or older and out of school system.)
Day Service	T2020	1 unit = 1 day (must equal minimum of 5 hours)
Family/Individual Support	S5126	1 unit = 1 day
Home Modifications	S5165	1 unit = 1 service
Medical Alert	S5161	1 unit = 1 month
Night Support	T2025	1 unit = up to 12 hours
Residential Services	T2016	1 unit = 1 day
Respite Care (Overnight)	H0045	1 unit = 1 day (limited to 60 days, per beneficiary, per calendar year.)
Respite Care (Temporary)	S5150	1 unit = 15 minutes (limited to 260 hours, per beneficiary, per calendar year.)
Respite Care (Emergency)	T1005	1 unit = 15 minutes (limited to 120 hours, per beneficiary, per calendar year.)
Screening	T2024	1 unit = 1 hour (one initial screening and an annual screening not to exceed 4 hours.)
Supportive Home Care	S5125	1 unit = 15 minutes
Targeted Case Management	T1017	1 unit = 15 minutes
Positive Behavioral Support (PBS)	90885 (22)	
PBS Treatment	90806 (22)	
PBS Person-Centered Planning	90882 (22)	
Van Lifts	T2039	1 unit = 1 lift
Wellness Monitoring	S5190	1 unit = 1 visit per 60 days
Wheelchair Modifications	T2029	1 unit = 1 service

Physically Disabled

Assistive Services	S5165	1 unit = 1 purchase (limited to max lifetime purchase of \$7500.00 per consumer)
Independent Living Counselor	T1017	1 unit = 15 minutes (limited to 480 units per year)
Personal Services	S5126 (UC)	1 unit = 1 month

Personal Emergency Response Install	S5160	1 unit = up to twice per calendar year
Personal Emergency Response	S5161	1 unit = 1 month
Sleep Cycle Support	T2025	1 unit = 8 – 12 hours in any given 24 hour time period
Autism		
Consultative Clinical And Therapeutic Services	H2015	1 unit = 15 minutes
Intensive Individual Supports	H20019	1 unit = 15 minutes
Family stabilization services	S9482	1 unit = 15 minutes individual rate
Family stabilization services	S9482 HQ	1 unit = 15 minutes group rate
Respite Care Services	T1005	1 unit = up to 15 minutes
Family Training and Counseling for Child Development	T1027	1 unit = 15 minutes individual rate
Family Training and Counseling for Child Development	T1027 HQ	1 unit = 15 minutes group rate

HCBS FREQUENT QUESTIONS

1. I am a new HCBS provider and I billed last week, I am showing I should be getting a check but I have not got it yet. Why?

There is a three to four week waiting period for HCBS providers to get their first check. If it has been past a month and you have not received a check please contact KMAP Customer Service.

2. How often can I submit a claim to the Kansas Medical Assistance Program?

The Kansas Health Policy Authority recommends submitting your claims weekly, twice a month, or monthly.

3. What is the payment schedule?

Claims processed by 5 p.m. on Friday are typically finalized for payment the following week on Thursday periodically the State delays a payment delay due to a holiday or other event.

4. Are taxes withheld from the payments?

No, taxes are not withheld from claim payments.

5. Will I receive a tax statement?

Yes, the state of Kansas will send out a 1099 for to providers who have a payment over \$600.00.

6. Do I ever have to file a paper claim? If yes, where do I find the paper claim form?

No, the KMAP Web site allows claim submission, adjustments, and voids. However, claims that require timely filing approval must be submitted by paper. KMAP and EDS do not furnish paper claims. For information to obtain paper claim forms, please visit the CMS Web site at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp.

7. What is a plan of care?

A plan of care is a document completed following the determination of eligibility for one of the many Home and Community Based Service (HCBS) programs. This document is subject to approval by the administrator of the HCBS Program. The plan of care must contain the following information:

- the services to be provided
- the frequency of each service
- who will provide each service
- the cost of each service.

The plan of care is entered electronically which allows waiver services claims to process in the KMAP system.

- The Area Agency on Aging creates plans of care for the frail elderly (FE) waiver.
- Community Developmental Disability Organizations (CDDOs) submit plans of care for the mental retardation/developmental disabilities (MRDD) waiver in most areas.
- Beneficiary caseworkers submit plans of care for the physically disabled (PD) waiver.

If you experience payment problems and the denial code indicates Prior Authorization Required, please contact one of the agencies listed above.

8. Can I get paid by submitting my worksheet directly to KMAP for payment?

No, the provider must calculate the information on your worksheet and submit a claim form for payment via the KMAP Web site or Provider Electronic Solutions (PES), or on paper.

9. Is there any dental coverage for people on an HCBS waiver?

Effective with dates of service on and after April 1, 2007, oral health services are available to adults ages 21 and older who are enrolled in the Home and Community Based Services Mental Retardation/Developmental Disabilities (MR/DD), Traumatic Brain Injury (TBI; previously referred to as HI), and Physically Disabled (PD) waiver programs. Refer to Exhibit D in the *Dental Provider Manual* for services available for HCBS MR/DD, TBI, and PD adult beneficiaries.

Further clarification regarding these services is as follows:

1. Beneficiaries ages 21 and older who are enrolled in the HCBS MR/DD, TBI, and PD waiver programs have medical cards indicating they are waiver recipients. On the medical card, the Living Arrangement field contains the following codes for the appropriate waiver:
 - MR/DD: HC-DD
 - PD: HC-PD
 - TBI: HC-HI
2. Providers must submit claims for beneficiaries in the same manner as other KMAP dental claims. Primary dental coverage for beneficiaries is provided under the Title 19 adult benefit plan.
 - If questions arise regarding oral health services provided through an HCBS waiver, call the HCBS-MR/DD, TBI and PD Program Managers at (785) 296-3561.

The funds to pay for HCBS dental services come from a separate fund than regular KMAP dental services. When providing dental services covered under the HCBS waivers (DD, TBI, or PD), you can receive two separate checks with your weekly remittance advice: one for regular KMAP services and one for the HCBS services. The total of these two checks will equal the net payment indicated on the summary page of your remittance advice.