Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Local Education Agency

Updated 01.2023

PART II
LOCAL EDUCATION AGENCY FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

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

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

PART II
LOCAL EDUCATION AGENCY FEE-FOR-SERVICE PROVIDER MANUAL
Updated 12/17

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to local education agency (LEA) providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection explains the method of billing applicable to LEA services.

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

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

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees 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.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality 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.

The Kansas Medicaid Fraud Control Act (K.S.A. 2004 Supp. 21-3844 to 21-3855) requires that providers keep records for five years from the date of payment or, if the claim does not pay, the date when the provider submitted the claim.

LEAs must verify that none of the practitioners providing services have been terminated, suspended, or barred from the Medicaid or Medicare program.
The following websites can be used for screening terminated, suspended, and barred providers.

- System for Award Management (SAM) – Click the Search Records button.
- Office of Inspector General (OIG) U.S. Department of Health & Human Services

7000. LOCAL EDUCATION AGENCY BILLING INSTRUCTIONS Updated 11/17

LEA providers must submit claims electronically. Refer to your *Paperless Claim Manual* for instructions.

Call the Electronic Data Interchange (EDI) department at 1-800-933-6593, option 1, then option 4, for the method that best fits your needs. Full training and support are provided.

Claims must be based on documentation of services provided. Billing based on the intent to provide care (such as Individualized Education Program [IEP] planned services, automated recurring billing, or group listings) is not allowed.

7010. LOCAL EDUCATION AGENCY BILLING INFORMATION Updated 07/10

Place of Service Codes

The only allowable place of service values: 03-school or 12-home.

Nursing Attendant Codes

The only allowable place of service values: 03-school or 12-home.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 08/08

LEA services are exempt from copayment requirements.

BENEFITS AND LIMITATIONS

8300. BENEFIT PLAN Updated 10/13

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

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 11/18

Medicaid reimburses LEAs for medically necessary services for the child to receive a free and appropriate public education, as documented on the child's IEP. Payment is made to LEAs approved by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) for services provided through KMAP as listed in Appendix I.

Only covered medically necessary services identified on the child's IEP will be eligible for reimbursement. A yearly KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) screening service performed by an LEA provider does not require an IEP. LEAs are required to provide documentation of findings identified during an annual KBH-EPSDT screen to the member's primary medical provider. KBH-EPSDT screening *CPT*® codes performed more frequently than once per calendar year must be included in an IEP and meet medical necessity. Refer to the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Provider Manual* for further information regarding EPSDT screening requirements.

Ongoing services can be addressed on the Individualized Healthcare Plan (IHP), behavior intervention plan (BIP), and/or assisted technology plan. These plans must be identified in the IEP as well as attached to it.

Providers of Medicaid-reimbursable services in an LEA must have appropriate credentials as described in the Medicaid State Plan and as required by the Kansas State Department of Education (KSDE). Professionals are expected to supervise the work of same-type paraprofessionals and confine the scope of practice to the usual and customary for their profession/paraprofession.

Services delivered by an LEA do not require a referral from the child's Medicaid managed care provider. A physician's order/authorization for the services being billed must be obtained prior to submitting claims to Medicaid. The only exception includes the provision of evaluations which may be completed without a physician order/authorization. A Release of Information must be on file before a Physician Authorization can be requested. All medical services must be authorized by a physician, doctor of osteopathic medicine, naturopath, physician's assistant, or nurse practitioner. This includes recommendations for specific programs, providers, methods, settings, frequency, and intensity of services. The Physician Authorization form must specify which services the physician is certifying for each student. Backdating is **not** allowed. In accordance with Code of Federal Regulation 42 CFR 455.440, the state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items of service. The NPI of the ordering, referring, attending, prescribing, or sponsoring (ORAPS) provider must be present on claims when submitted or they will be denied. The provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

Services must be **medically necessary** and may be habilitative or rehabilitative for maximum reduction of disability and restoration to the best possible functional level. Services which are educationally necessary but not medically necessary will not be covered. Services must be approved and provided by an Early Childhood Intervention (ECI), Head Start, or LEA program.

8400. MEDICAID Updated 10/18

An evaluation for physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) is not Medicaid-reimbursable unless an IEP is developed which includes a recommendation for ongoing services in that same therapy type. If the assessment does not reveal "medical necessity" for the services, the assessment cannot be billed. IDEA-driven evaluations are Medicaid-reimbursable only for students determined to have a disability.

In the case that an evaluation for a child is conducted across a time period involving more than one day (for example, 15 minutes carried out on Day 1, 15 minutes on Day 2, etc.), the practitioner should not submit a bill until the date of completion for that evaluation. Each of the service codes may be billed once per evaluation per child on the date of completion of that evaluation. Multiple bills must not be submitted for the same evaluation for the same child, even if it is conducted over the course of more than one day.

Therapy should be provided only for individuals with a Physician Treatment Plan, an IEP, or an IFSP. A physician's order/authorization is required for physical, speech, occupational, and other therapies. Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit. If a student is receiving therapies outside of the school setting, documentation within the IEP must include the details of therapy and clearly reflect there is not duplication of service. Coordination of care must be maintained.

- OT services must be provided by a registered occupational therapist or by a certified occupational therapy assistant working under the supervision of a registered occupational therapist.
- PT services must be provided by a registered physical therapist or by a certified physical therapy assistant working under the supervision of a registered physical therapist.
- SLP services must be provided by a registered speech-language pathologist or audiologist.

Supervision must be clearly documented. This may include, but is not limited to, the registered occupational therapist or physical therapist initializing each treatment note written by the certified occupational therapy assistant or physical therapy assistant, or the registered occupational therapist or physical therapist writing "Treatment was supervised" followed by his or her signature. At least once every sixth visit by the occupational therapy assistant or physical therapy assistant or at least once every 30 calendar days (whichever comes first), the registered occupational therapist or physical therapist must visit the patient. The supervising therapist must review and countersign the assistant's documentation within five days of the information being recorded.

For a make-up therapy session to be Medicaid-reimbursable, it must be consistent with the order/authorization and must:

- Be a service documented in the IEP
- Occur within the week of any missed visit
- Be documented
  Note: Session notes must be kept for each session including make-up sessions.
- Be provided by a qualified Medicaid provider
- Fit with the desired treatment outcome

8400. MEDICAID Updated 06/16

Cotreatment consists of more than one professional providing treatment at the same time. Therapists or therapist assistants working together as a "team" to treat one or more individuals **cannot** bill separately for the same or different services provided at the same time to the same individual. For cotreatments, only one *CPT* code may be billed per session (untimed *CPT* codes) or per unit (timed *CPT* codes).

Either one therapist can bill for the entire service or the therapists can divide the service units (if applicable) where an occupational and physical therapist (timed *CPT* code) both provide services to one individual at the same time. Only one discipline per session may be billed where a SLP (untimed *CPT* code) and an occupational or physical therapist (timed *CPT* code) both provide services to one individual at the same time.

To calculate billing units, count the total number of billable minutes for the calendar day for the student and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven. They are converted to 0 units of service if they are seven minutes or less.

Billing Therapy Services

0-7 minutes	=	0 units
8-22 minutes	=	1 unit
23-37 minutes	=	2 units
38-52 minutes	=	3 units
53-67 minutes	=	4 units
68-82 minutes	=	5 units

The time (minutes) for all nursing services delivered to a student during a calendar day must be added together before they are converted to units of service.
Nursing attendant care services may be billed by LEAs for students with those services in their IEPs.
Specific services allowed include S9123 (by RN, per hour) and S9124 (by LPN, per hour).
The LEA may use its own employees or contracted staff from another agency to provide these services.

Billing Nursing Attendant Care

0-5 minutes	–	0 billable units
6-11 minutes	–	0.1 billable units
12-17 minutes	–	0.2 billable units
18-23 minutes	–	0.3 billable units
24-29 minutes	–	0.4 billable units
30-35 minutes	–	0.5 billable units
36-41 minutes	–	0.6 billable units
42-47 minutes	–	0.7 billable units
48-53 minutes	–	0.8 billable units
54-59 minutes	–	0.9 billable units
60-65 minutes	–	1 billable unit

A physician-selected ICD diagnosis code must identify the condition for which the member is receiving services. For dates of service prior to October 1, 2015, an appropriate diagnosis code would be 78340. For dates of service on and after October 1, 2015, an appropriate diagnosis code would be R6250.

8400. MEDICAID Updated 07/18

Social work services must be provided by or under the direction of a licensed social worker in accordance with 42 CFR 440.60 (a). The school social worker must hold a current and valid license issued by the Behavioral Sciences Regulatory Board, at the licensed master social worker (LMSW), licensed specialist clinical social worker (LSCSW), or temporary licensed master's social worker (TLMSW or LMSWT) level. (Minimum supervisory requirements apply.)

Psychological services must be provided by or under the direction of a licensed psychologist in accordance with 42 CFR 440.60 (a). The psychologist must be licensed by the Behavioral Sciences Regulatory Board and/or licensed and endorsed by KSDE as a "school psychologist". (Minimum supervisory requirements apply.)

Social work and psychology services limitations include the following:

- Individual counseling reimbursement is limited to a combined total of two hours (four units) per calendar week.
- Group counseling reimbursement is limited to a combined total of one hour (two units) per calendar week.
- Psychological testing reimbursement is limited to a total of three hours per school year.
- Reimbursement is one hour equals one unit. For those individuals that cannot participate in a full hour of testing, the testing can be broken out into 15-minute increments as follows:
    - 0-5 minutes = 0 units
    - 6-15 minutes = .25 units
    - 16-30 minutes = .5 units
    - 31-45 minutes = .75 units
    - 46-60 minutes = 1 unit
- Development testing reimbursement is limited to one session per school year.

Documentation of all services performed is required and must include:

- Date, time, and detailed description of each intervention/service delivered and by whom (name, designation of profession or paraprofession)
- Duration of the service
  Note: This must include start time and duration and/or stop time.
- Assessment and response to intervention/service using objective measures allowing the reader to determine progress toward goal(s)
- Progress toward achieving individualized long- and short-term goals

Documentation of services found to be conflicting with other documentation or schedules will result in full recoupment of involved services. Examples include but are not limited to:

- Performer is documenting the delivery of a direct service at the same or overlapping time for two beneficiaries.
- Performer is documenting the delivery of a service at the same or overlapping time as the performer is entering documentation into an LEA record.
- Performer is documenting the delivery of service prior to or during the reported treatment time.
- Member is documented as receiving two separate services at the same time or at overlapping times. ***Exception:*** Appropriately billed cotreatment.
- Performer is documenting the delivery of a service when the student is reportedly absent.
- Performer is documenting the delivery of a service when school is not in session.

Not all services provided by LEAs are billable. Examples include but are not limited to:

- Preparation for and attendance of IEP meetings
- Telephone calls/conferences/contacts
- Travel time
- Time spent in observation unless the description of the code specifies the allowance
- Missed services (i.e. student refusal, absent participation)
- Delegated services performed by an unlicensed or uncertified individual
- Nursing services for which a specialized skill is not required to perform
- Nursing services for which the documentation does not support delivery of specialized skills
- Time spent by clinicians in supervision or consultation
- Time spent for documentation/report writing unless the description of the code specifies the allowance
- Services involving an individual who has been excluded from participation in federally funded programs

Services provided by LEA providers are by law at no cost to the family. Because the services are at no charge to the family, most insurance companies consider these services as not covered by their policies. Therefore, KMAP does not require LEA providers to seek payment from private insurance companies to be eligible to receive Medicaid reimbursement. Similarly, KMAP will not seek reimbursement from the insurance companies.

However, KMAP does require all Medicaid providers to report insurance resources of which they become aware. This reporting assists KMAP in billing for other services that the other insurance company covers, such as hospitalization.

This policy does not prevent LEA providers from billing and collecting from insurance companies which do cover these services. If a provider anticipates that an insurance company will cover the services and the parents give the provider permission to bill the insurance, this private resource should be accessed prior to accessing taxpayer-funded Medicaid.

Telemedicine

Provisions in the Kansas Telemedicine Act will allow speech-language pathologists and audiologists licensed by the Kansas Department for Aging and Disability Services (KDADS) to provide services via telemedicine. Services must be provided via real-time, interactive (synchronous) audio-video telecommunication equipment that is compliant
with HIPAA.

The speech-language pathologist and audiologist may furnish appropriate and medically necessary services within their scope of practice via telemedicine. As documented in related telemedicine policies, telemedicine claims at the distant site must contain place of service 02 (Telehealth distant site). Providers at the originating site may submit claims using code Q3014 (Telehealth originating site facility fee).

- Distant site means a site at which the healthcare provider is located while providing healthcare services by means of telemedicine.
- Originating site means a site at which a patient is located at the time healthcare services are provided by means of telemedicine. The facilitator at the originating site must have the appropriate skill set to safely assist the speech-language pathologist or audiologist to provide safe, effective, and medically necessary services via telemedicine.

8400. MEDICAID Updated 01/23

The following codes are deemed appropriate to be furnished via telemedicine by the American Speech-Language and Hearing Association. Codes not appearing on the tables below are not covered via telemedicine.

Note: The GT modifier is no longer required when billing telemedicine services.

Speech-Language Pathology Codes

92507	92508	92521	92522	92523	92524
96110	96112	96113	97110	97112	97129
97130	97140	97161	97162	97163	97164
97165	97166	97167	97168	97530	97533
97535	97750				

Audiology Codes

92551	92552	92553	92555	92556	92557	92567

APPENDIX
CODES

Updated 01/23

The following codes represent a list of covered LEA services billable to KMAP.

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

- Information from the public website
- Information from the secure website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure websites. They can be accessed from the Reference Codes link under the Interactive Tools heading on the Provider page and Pricing and Limitations on the secure portion. Information is also available on the American Medical Association website.

AUDIOLOGY

92551	92552	92553	92555	92556
92557	92567			

KBH-EPSDT CODES

99173	99202	99203	99204	99205
99213	99214	99215	92551	99383
99384	99385	99393	99394	99395

NURSING

S9123	S9124	T1001	T1002	T1003

OCCUPATIONAL/PHYSICAL/SPEECH THERAPY

***These codes require a physician's order. The ordering, referring, attending, prescribing, or sponsoring provider's NPI must be present on the claim form when billing these services for payment.**

92507*	92508*	92521	92522	92523
92524	96112	96113	97110*	97112*
97113*	97116*	97129	97130	97140
97150*	97161	97162	97163	97164
97165	97166	97167	97168	97530*
97533*	97535*	97537*	97550	

PSYCHOLOGY THERAPY

96110	96127	96130	96131	99402
99411				

SOCIAL WORK THERAPY

96110	96127	99402	99411	