Nursing facility/swing bed

We will cover

- Client assessment, referral and evaluation (CARE) assessments
- *Quick Fax Sheet*
- Level of care (LOC)
- *MS-2126 Form*
- Eligibility verification
- Patient liability
- Transportation
- Leave days
- Hospice
- Swing bed
- Opioid products indicated for pain management
- Adverse Incident Reporting System (AIRS)
- Promoting Excellent Alternatives in Kansas (PEAK)
- Service coordination model
- Transitional services
- Amerigroup Kansas, Inc. provider website
- Contact information for providers

CARE

CARE assessment **is required** prior to admission unless the member meets the following criteria:

- If a person discharges to the nursing home from a hospital, the hospital assessor may complete the CARE assessment.
- A complete Level I CARE assessment is required before an individual may be admitted to a nursing facility, regardless of the resident's payer source. The only exceptions are the following special admissions:
    - An emergency admission
    - A respite stay
    - A less than 30-day admission
    - An out-of-state admission
    - A terminal illness

Sections A and B of the *CARE Assessment Form* must be sent to Kansas Department for Aging and Disability Services (KDADS) for every admission, even the exceptions above. The Kansas Association of Area Agencies on Aging and/or hospitals will submit the form for all other admissions. See https://www.kdads.ks.gov/provider-home/care-provider-information for more information.

Quick Fax Sheet

QUESTIONS REGARDING THE CARE PROCESS:
CALL .785.296.6446

Type of issue	What to do	Information to send	When
For Medicaid only MS-2126	FAX to **KanCare** at: 1-844-264-6285 Or mail: **The KanCare Clearinghouse;** PO Box 3599; Topeka, KS 66601	Fill out completely do not leave items blank. Use the new form MS-2126 Old forms will not be accepted after **August 31, 2017**	Please send form within 5 working days of the resident Admit. Fill out upon admission and discharge (If discharge will be for more than 30 days.)
Emergency Admissions*	Fax **local ADRC** and Fax to KDADS Care 785-291-3427 or e-mail KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Order if applicable 4. APS FORM (PPS 10510) if applicable	Send fax within one business day of admission. 7 days to complete Care Level 1 assessment.
Respite Stay*	Fax KDADS Care Staff at: 785-291-3427 or e-mail KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Respite order signed by Physician include **admit and discharge dates**	Send fax within one business day of patient admit to KDADS
Less than 30 Day Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Less than 30 day order **signed by hospital attending prior to admission***	Send fax within one business day of patient admit to KDADS On day 20, contact ADRC for CARE Level 1 assessment if patient stay will extend beyond Day 30.
Out of State Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE @ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Out of State PASRR signed and dated	Send fax within one business day of patient admit to KDADS
Terminal Illness Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Physician signed order stating 6 months or less to live 3. Sections A&B of the CARE Assessment	Send fax within one business day of patient admit to KDADS Terminal Illness Certification is good for 6 months from the date of the signed order
Request for Resident Review*	FAX KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	1. Resident Review Check List 2. Release of Information Form	Three weeks prior to end of previously authorized stay OR as soon as MI/ID/DD is discovered Questions Contact: 785.291.3360
CARE Assessment*	Contact your local ADRC to schedule an appointment	**None**	On or before admission to the nursing facility, regardless of payer source.

***REGARDLESS OF PAYMENT SOURCE - One of the above types of admission paper work is REQUIRED for all residents entering a Medicaid certified nursing facility** (02/13/2018)

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Member LOC

- The LOC on file with Kansas Department of Health and Environment (KDHE) does not support payment of a nursing facility claim.
- Per State of Kansas policy, a managed care organization (MCO) must ensure a member has the correct LOC on file prior to paying a provider claim for a nursing facility, swing bed, psychiatric residential treatment facility (PRTF) or intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IDD).
- If the LOC does not match the type of claim being billed, the claim will deny and cannot be reprocessed for payment until the member LOC has been updated by the KanCare Eligibility clearinghouse.
- It is critical for providers to check the member LOC every time the member has left and returned to the facility to ensure it remains correct for the type of claim being billed.

KMAP *MS-2126 Form*

LOC/living arrangement coded by KanCare clearinghouse — How does this affect my claims?

- There are a number of factors that can affect the approval of the LOC by the worker. Factors such as transfer of property, failure to receive a CARE, excess resources, etc. can impact the eligibility of the applicant. The LOC code means the person has been approved for long-term care.
- Claims can only be paid to nursing facility providers when the LOC coding approves the nursing facility stay. If the LOC coding is not correct, the nursing facility claims will deny.
- The LOC coding is reported on the KMAP website. This allows providers to verify the LOC data has been updated by the clearinghouse. The usual LOC for nursing facility coding is **nursing facility**. Until this coding is available on KMAP, the providers will not be able to be paid for the stay.
- There are times when a home- and community-based services (HCBS) beneficiary will temporarily enter a nursing facility. The LOC coding reflects the temporary stay. Coding will report as temporary care with the applicable HCBS waiver code (e.g., FE, PD, DD, etc.). If the stay becomes permanent, the temporary coding is changed to the routine nursing facility LOC coding by clearinghouse.

MS-2126 Instructions

1. This form can only be submitted by a facility.

2. The facility initiates the MS-2126 under the conditions specified in Medical KEESM 8184.1 within 5 days of the event/request. Specific conditions prompting an MS-2126 include:
   - A Medicaid 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

3. Sections A and B are always completed.

4. Sections C through F are completed as necessary.
   - Section C: CARE/PASRR/Pre-Admission Screening – This section is required for new admissions and new Medicaid requests. Responses to questions 1, 2 and 3 are required for all facilities except PRTF. For PRTF, a response to question 4 is required.

     Important: It is the responsibility of the admitting facility to ensure these requirements are met. A CARE Assessment is not required for State Hospitals, ICF/IID, Swing Bed, or PRTF placements.

   - Section D: Facility Admission – Required for new admissions, new Medicaid requests and any Level of Care change in the facility.

   - Section E: Temporary Absence - A form is only necessary if the resident will be temporarily absent more than 30 days from your facility. If the absence is for 30 days or less, a form is not required. Note regarding a resident temporarily residing in a Swing Bed - the original facility will not be paid for the absence. See the KMAP Provider Manual for information.

   - Section F: Discharged or Deceased - Complete this section if the resident has discharged and will not return to your facility or if the resident passed away.

5. If the resident is in State (DCF or KDOC) or Tribal custody, note this in Section A under Responsible Person or Agency. Contact the designated individual in the DCF Regional Service Center if additional information is needed.

6. For PRTF, follow processing guidelines outlined in the appropriate KMAP provider manual regarding prior authorization.

7. The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. The form may be faxed (1-844-264-6285) or mailed:

   The KanCare Clearinghouse
   P.O. Box 3599
   Topeka, KS 66601-9738

8. The KanCare Clearinghouse will notify the facility when the case is approved or denied.

NOTE: Incomplete forms may not be processed timely and may be returned to the facility.

C. CARE/Pre-Admission Screening (Responses to all Questions Required)

1. Is a CARE/Pre-Admission Screening Required? ☐ No ☒ Yes

If No, provide reason: _____

2. Is a CARE/Pre-Admission Screening Delayed? ☐ No ☐ Yes (if yes complete the following section)

☐ Emergency Admission Date to KDADS: _____

☐ 30 Day Provisional (resident expected to stay past 30 days) Date to KDADS: _____

☐ 30 Day Provisional (short-term stay) Date to KDADS: _____

☐ Out of State Admission Date to KDADS: _____

☐ Terminal Illness Date to KDADS: _____

3. Was the CARE/Pre-Admissions Screening Completed? ☐ No ☐ Yes ☐ Not Applicable

CARE Date: _____ CARE/Level 2, Date: _____ Other, Date: _____

If the CARE/Pre-Admission Screening is required, but was not completed, list reason below:

_____

Sections C through F are completed as necessary.

- Section C: Care Pre-Admission Screening – This section is required for new admissions and new Medicaid requests. Responses to questions 1, 2 and 3 are required regardless of the type of facility.

  Important: It is the responsibility of the admitting facility to ensure these requirements are met. A CARE Assessment is not required for Swing Bed placements.

MS-2126 Form instructions

D. Facility Admission

1. Date admitted to your facility: _____

2. Anticipated Length of Stay:

☐ Less than 30 days ☐ Temporary - Anticipated length: _____ ☐ Permanent

3. Current Level of Care in Your Facility:

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

- Section D: Facility Admission – Required for new admissions, new Medicaid requests and any Level of Care change in the facility.

Where to send the *MS-2126 Form*

- The following facilities are required to submit an *MS-2126 Form* anytime a member is admitted to or discharged from their facilities:
  - Nursing facilities
  - Swing bed facilities
  - PRTF
  - ICF/IDD

Where to send the *MS-2126 Form* (cont.)

Send required forms to the KanCare clearinghouse and Amerigroup:

Clearinghouse

- Fax for elderly and disabled: 1-844-264-6285
- Mailing address:
  KanCare Clearinghouse
  P. O. Box 3599
  Topeka, KS 66601

Amerigroup

- Email: kscasespec@amerigroup.com

It is critical that these forms be completed and submitted as soon as the admission or discharge date is known to ensure correct claims payment.

Please make sure to use the *MS-2126 Form* dated April 2018.

More information is available at http://kancare.ks.gov/docs/default-source/policies-and-reports/KDHE-KEESM/KFMAM-Medical-Forms/external-forms/ms-2126-4-18.pdf?sfvrsn=2.

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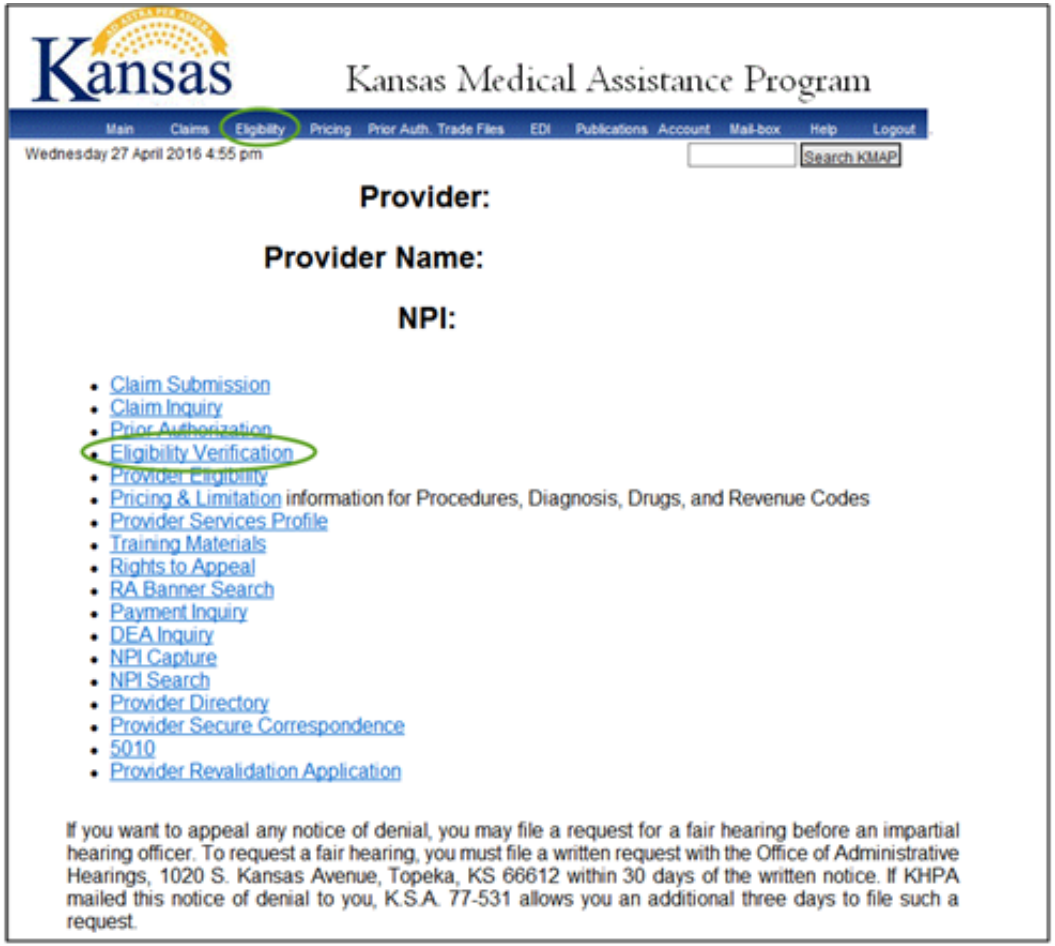
Claim denial

- The member LOC does not support the claim billed.
- For CO150: the payer deems the information submitted does not support this level of service.
- For CO186: there was an LOC change adjustment.
- The LOC on file with KDHE does not support payment of a nursing facility claim.
- Per State of Kansas policy, an MCO must ensure a member has the correct LOC on file prior to paying a provider claim for a nursing facility, swing bed, PRTF or ICF/IDD.
- If the LOC does not match the type of claim being billed, the claim will deny and cannot be reprocessed for payment until the member LOC has been updated by the KanCare eligibility clearinghouse.
- It is critical for providers to check the member LOC anytime the member has left and returned to the facility to ensure it remains correct for the type of claim being billed.

Eligibility verification

Eligibility verification can be accessed from the provider page. The *Eligibility* tab appears on the menu bar at the top of the page, and the *Eligibility Verification* link is found below the provider information.

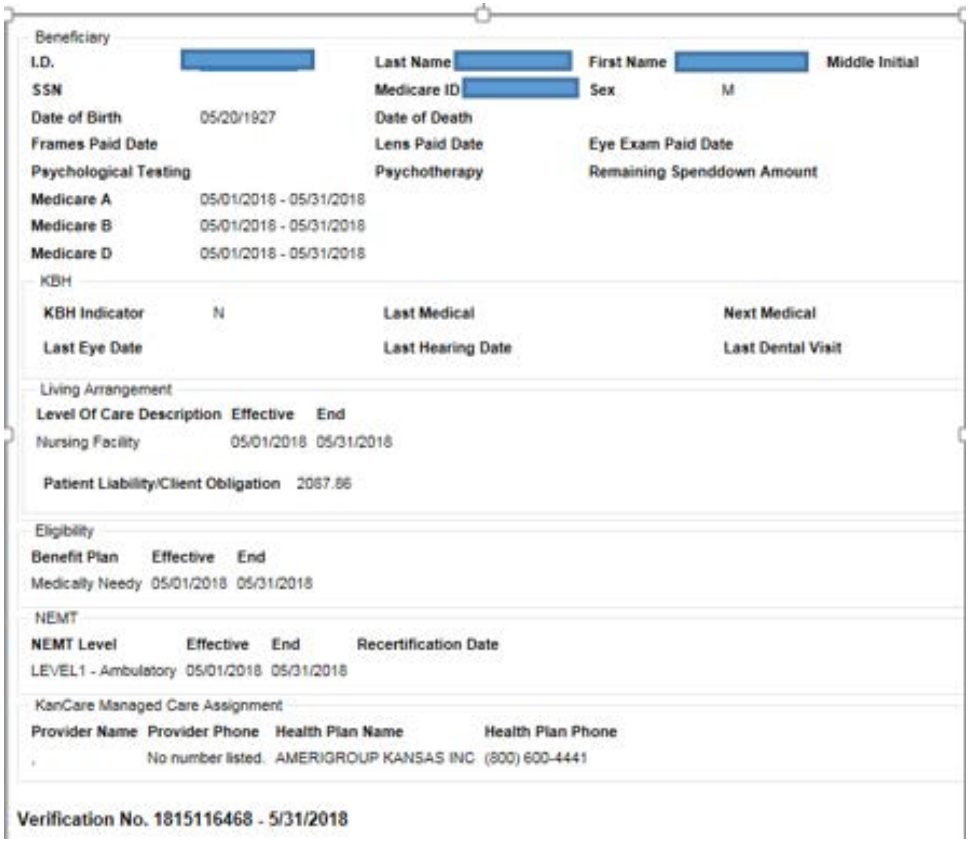


Eligibility verification (cont.)

- Verify that living arrangement and benefit plan reflects waiver eligibility. Pay close attention to effective dates.
- Applicable patient

  liability — nursing facility or client obligation (HCBS/temporary stay) will be listed here.

  * HCBS provider will continue to collect the obligation for a temporary stay.
- Following clearinghouse updates, KMAP information is updated within 24 hours. MCOs are then updated.



Beneficiary

I.D. [redacted] Last Name [redacted] First Name [redacted] Middle Initial

SSN Medicare ID [redacted] Sex M

Date of Birth 05/20/1927 Date of Death

Frames Paid Date Lens Paid Date Eye Exam Paid Date

Psychological Testing Psychotherapy Remaining Spenddown Amount

Medicare A 05/01/2018 - 05/31/2018

Medicare B 05/01/2018 - 05/31/2018

Medicare D 05/01/2018 - 05/31/2018

KBH

KBH Indicator N Last Medical Next Medical

Last Eye Date Last Hearing Date Last Dental Visit

Living Arrangement

Level Of Care Description	Effective	End
Nursing Facility	05/01/2018	05/31/2018

Patient Liability/Client Obligation 2087.86

Eligibility

Benefit Plan	Effective	End
Medically Needy	05/01/2018	05/31/2018

NEMT

NEMT Level	Effective	End	Recertification Date
LEVEL1 - Ambulatory	05/01/2018	05/31/2018	

KanCare Managed Care Assignment

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
,	No number listed.	AMERIGROUP KANSAS INC	(800) 600-4441

Verification No. 1815116468 - 5/31/2018

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Patient liability

This is the amount a member will pay for services while in a nursing home. This amount will be deducted from nursing facility, swing bed, hospice (T2046 only), ICF/IDD and PRTF claims each month. The member is responsible for paying this amount each month. Please note, when a member has a temporary stay, patient liability is not applied.

What if the monthly patient liability amount deducted from my claim is different than the amount in the letter from the KanCare clearinghouse?

The monthly patient liability is the amount the KanCare beneficiary is responsible to pay the nursing facility. This amount is set by the KanCare clearinghouse based on the income, protected income level, and applicable medical expenses of the beneficiary. This amount can change. When a change in the monthly liability is made, the nursing facility should receive a written notice from the clearinghouse.

Patient liability (cont.)

- You can find the monthly liability amount using the KMAP website eligibility verification link. The amount reported for the eligibility period indicated on the website *is* the amount that will be deducted from your claims. The nursing facility is expected to collect this amount each month from the KanCare beneficiary.
- If the amount reported on the KMAP website eligibility verification link does not match the amount reported on the notice from the clearinghouse, the nursing facility **must** contact the clearinghouse to resolve the issue. If the amount on the website is correct and matches the letter, then work with the appropriate MCO to verify they have the correct information.

Assistance for nursing facility member liability collection

1. The provider contacts the Amerigroup service coordinator.
2. The service coordinator will discuss issue with the member/family to identify barriers.
3. The service coordinator will determine if a barrier is due to disability.
4. The service coordinator will address any suspected misappropriation of funds (if necessary).
5. The service coordinator will request/review any documentation related to nonpayment.
6. Amerigroup will submit documentation to the State, provider and the member/family to advise of the impact of continued service and steps to resolve the dispute.
7. If the matter is unresolved, Amerigroup and provider will:
    - Convene a meeting with all parties.
    - Review the patient's liability obligation.
    - Attempt to resolve the issue with a mutually agreed-upon plan.
    - Explain options for transfer/discharge.

Nursing facility transportation

Can my facility be reimbursed for transporting a KanCare nursing facility resident?

The cost of transporting a current nursing facility resident for nonemergent services (either by ambulance or commercial nonambulance medical transportation) is the responsibility of the nursing facility. This includes new admissions to the nursing facility. These expenditures should be included in the provider's cost report.

Nursing facility leave days

How many hospital and home leave days does a resident have per year?

- KanCare allows up to 10 days per confinement for reservation of a bed when a nursing facility, nursing facility/mental health or ICF beneficiary leaves the facility and is admitted to an acute care facility. This applies when conditions under the reserve day regulations are met. If the resident is readmitted to the nursing facility, the 10-day limitation resets.
- When a resident is admitted/transferred to a swing bed facility, the swing bed days are not billable to the MCO as hospital leave days for the nursing facility because the stay is no longer considered acute care. The hospital should notify the nursing facility and the KanCare clearinghouse (via the *MS-2126 Form*) of the swing bed admission.

Nursing facility leave days (cont.)

- When a nursing facility/mental health resident leaves the facility and is admitted to one of the state mental hospitals, a private psychiatric hospital, Prairie View Mental Health Center or a psychiatric ward in an acute care hospital, KanCare allows up to 21 days per admission for reservation of a bed.
- A maximum of 18 home leave days for nursing facilities and 21 days for nursing facility/mental health are allowed per calendar year.
- KanCare will not reimburse for days a bed is held for a resident beyond the limits set forth above. Days beyond the limitations are considered noncovered and potentially billable to the resident if notified in advance and in writing of this facility policy.

Revenue codes utilized for nursing facility leave

- REV 0180 – General leave of absence
- REV 0183 – Therapeutic leave of absence
- REV 0185 – Nursing home leave of absence (hospitalization)
- REV 0189 – Other leave of absence; noncovered days

Reimbursement for reserve days is calculated based on

67 percent of the all-inclusive per diem rate by facility (with the exception of REV 0189).

Nursing facility hospice election

- How are claims billed for room and board and hospital leave days when a member elects hospice?
- Payment will be made to the hospice for room and board and leave days for those members who have elected hospice coverage. Hospice providers are required to bill the room and board charges for hospice beneficiaries residing in nursing facilities, ICF/IDD or hospital swing beds. Nursing facilities include skilled nursing facilities and nursing facilities for mental health. ICF/IID include privately owned and state institution ICF/IID. No payment will be made to the nursing facility.

Nursing facility hospice election (cont.)

- The nursing facility and hospice will have an agreement in place to specify the processes for collecting the monthly patient liability and reimbursement from hospice provider.
- The nursing facility will submit a bill for room and board and leave days to the hospice provider; this will prompt the hospice provider to reimburse the nursing facility. This process is established in an agreement between the two providers.
- Hospice providers are paid at 95 percent of the nursing facilities' per diem rate.
- If the nursing facility rate changes, the nursing facilities must notify the hospice providers so the hospice provider may submit corrected claims with the appropriate rate for payment.

Swing bed

When billing for a swing bed nursing facility, the following must be observed:

- Your hospital must be certified by the KDHE as a swing bed nursing facility hospital.
- The facility retains the original *MS-2126* and submits a copy to the KanCare clearinghouse. The KanCare clearinghouse will notify the facility when payment is approved or denied. The facility will also be notified of the effective date and any applicable patient liability:
    - Swing bed hospital claims will be denied unless the appropriate LOC information is present. A living arrangement code/LOC code of *nursing facility swing bed* show approval by the clearinghouse beginning with the date payment is approved. The clearinghouse will compute the patient liability, and this information will be reported to the swing bed facility.
    - For persons moving to or from a regular nursing facility or other institutional living arrangement to a swing bed facility, the liability will be assigned to the first living arrangement of the month. If the individual is moving to another swing bed facility, the liability is assigned to the first paid claim(s) for the month.

Swing bed (cont.)

Coding must also be adjusted for current HCBS waiver participants who temporarily enter a swing bed hospital arrangement as well. A living arrangement code of temporary care, in combination with the appropriate wavier code (e.g., PD, FE) will also permit payment of swing bed hospital payments. Patient liability rules in place for HCBS-TC situations are also applicable to swing bed facilities, where the obligation will continue to be assigned to HCBS services only.

MS-2126 Form

Sections A, B, C and D are required.

- C: answer all questions
- 1) Select *No* – Swing bed admission
- 2) Select *No*
- 3) Select *Not Applicable*
- D: answer all questions 1-5D3 — select swing bed (ICF/nursing facility/swing bed)

For more information , see http://kancare.ks.gov/docs/default-source/policies-and-reports/KDHE-KEESM/KFMAM-Medical-Forms/external-forms/ms-2126-4-18.pdf?sfvrsn=2.

Swing bed (cont.)

- Providers must bill the full amount and the patient liability will be automatically deducted during processing. When billing for a swing bed, a separate claim must be submitted for each calendar month.
- **Note**: Do not attach a copy of either the *MS-2126* or *Notice of Action* to your claim form.
- Bill all nursing facility days for eligible Medicare patients to Medicare first. Medicaid can be billed for any remaining amounts using the inpatient Medicare claim crossover method (refer to Section 3200 of the *KMAP General TPL Payment Fee-for-Service Manual*). If Medicare will not pay for the intermediate care facility days, a copy of either the *Medicare Report of Eligibility* (*ROE*) or a Medicare denial must be attached to the Medicaid billing supporting nonpayment by Medicare.

Swing bed (cont.)

- Before a transfer to a swing bed nursing facility occurs, the patient must be discharged from the inpatient unit. Use the appropriate three-digit type of bill code on the *UB 04* or electronic equivalent. (Refer to Section 7000 of the *KMAP Hospital Manual.*)
- The inpatient unit is not reimbursed for the date of discharge since the swing bed nursing facility will be reimbursed for the date of admission.

Swing bed (cont.)

Room and board: room and board charges are billed separately from the ancillary charges. Swing bed room and board claims are billed using the same methods as other inpatient claims with the following exceptions:

Type of bill must be 18X for the claim to process as a swing bed claim. Choices for third digit are:

- 0: Nonpayment/zero claim
- 1: Admit through discharge claim
- 2: Interim — first claim
- 3: Interim — continuing claim
- 4: Interim — last claim (through date is discharge date)

Swing bed (cont.)

The appropriate accommodation revenue code applicable to the patient's LOC must be entered in FL 42. Bill the total number of days in FL 46 (units). In FL 47, place the total charge of days billed. For further information on per diem supplies and services, including durable medical equipment, pharmacy, therapy, transportation and miscellaneous items, refer to Section 8400 of the *KMAP Nursing/Intermediate Care Facility Fee-for-Service Provider Manual*.

Swing bed (cont.)

- ***Ancillary charges***: Cannot be billed on the swing bed nursing facility claim. Any ancillary services received by the patient while in a swing bed nursing facility must be billed on a *UB-04* paper or electronic equivalent claim form using the outpatient type of bill code (FL 4) and the correct HCPCS code and revenue code for the ancillary services provided. Indicate condition code D9 (any other change) in FL 18-28, and enter the from and through dates of service in FL 6 on the *UB-04* paper or electronic equivalent claim form. When multiple dates of service are being billed, enter only the first date of service in FL 45 on the *UB-04* paper or electronic equivalent claim form.
- ***Pharmacy***: Pharmacy services for swing bed claims need to be billed on a pharmacy claim form from a Medicaid-enrolled outpatient pharmacy. Refer to the *KMAP Pharmacy Fee-for-Service Provider Manual* for billing instructions and coverage information.

Swing bed (cont.)

- ***Supplies***: When billing for supplies provided by the swing bed facility over and above the supplies included in the reimbursement rate, use procedure code **99070 — bill one unit per day**. Claims must include both revenue codes and HCPCS codes.
- With the exception of the billing guidelines we just addressed, the remainder of the claim form is to be completed in the same manner as an inpatient submission (refer to instructions in Section 7000 of the *KMAP Hospital Fee-for-Service Manual*).

Swing bed (cont.)

A hospital may not charge KanCare members for providing routine supplies and services since:

- The hospital is required to provide routine supplies and services to KanCare swing bed patients.
- The cost of providing routine supplies and services is included in the hospital's swing bed per diem reimbursement.

Swing bed (cont.)

- *Routine* is defined as an item that is commonly stocked for use by anyone. It is an item that may or may not be specifically assigned or prescribed to any one patient. Routine items covered by the drug program when ordered by a physician for occasional use are included in the per diem reimbursement. Since items considered to be routine for residents of adult care homes are also considered to be routine for swing bed nursing facility patients, refer to Appendix III for a descriptive list of routine items. Any routine item billed on the outpatient hospital claim form will be denied.
- *Nonroutine* is defined as a specifically prescribed item for a resident for an acute or chronic need. Medication orders may be considered nonroutine if it is not a stock item of the facility or it is a stock item with unusually high usage by the individual.

Swing bed (cont.)

With the exception of the billing guidelines addressed above, the remainder of the claim form is to be completed in the same manner as an inpatient or outpatient submission. Refer to instructions in Section 7000 of the *KMAP Hospital Manual.*

Swing bed room and board daily rates:

- 2018 — $143.01
- 2017— $141.17

KanCare opioid products indicated for pain management PA

Effective June 1, 2018:

- Criteria will apply to all patients covered under KanCare.
- Information on the KanCare opioid products indicated for pain management prior authorization (PA) is available on the following links:

Prior Authorization — Clinical Criteria

http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm

Class-Specific Clinical PA Forms

http://www.kdheks.gov/hcf/pharmacy/pharmacy_class_specific_clinical_pa_forms.htm

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KanCare opioid products indicated for pain management PA (cont.)

- **Short-term/acute pain opioid user** (patients who have received opioid prescription[s] for **< 90 days in a look-back period of four months)**:
  - Limit of **seven-day supply** of short-acting opioid (e.g., immediate release formulation):
    - Up to 14-day supply is allowed within a 60-day look-back period.
    - Must be no more than seven-day supply per prescription.
- Daily limit of **90** morphine milligram equivalent (MME):
  - PA is required for all long-acting opioid prescriptions (e.g., extended release formulations).
  - PA is required for any short-acting opioid prescriptions exceeding the short-term/acute pain use day supply or **90** MME limits.

KanCare opioid products indicated for pain management PA (cont.)

- **Chronic opioid user** (patients who have received opioid prescription[s] for **≥ 90 days in a look-back period of four months**):
  - PA required (for any duration)
- **Patients with cancer, sickle cell, or hospice/palliative care** diagnosis in paid medical claims will be exempt from the seven-day supply and MME limits and long-acting PA edit.
- **Buprenorphine products for opioid dependence** (e.g., SUBOXONE®) are **not** affected by this policy.

Notification requirements/reporting adverse incidents to Amerigroup

- Providers must complete an AIRS and notify Amerigroup and all appropriate agencies of adverse incidents.
- Examples of adverse occurrences/incidents include but are not limited to:
  - Treatment complications, including medication errors and adverse medication reactions.
  - Accidents or injuries to a member.
  - Morbidity.
  - Suicide attempts.
  - Death of a consumer.
  - Allegations of physical abuse, sexual abuse, neglect and mistreatment, and/or verbal abuse.
  - Use of isolation, mechanical restraint or physical holding restraint.
  - Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members.

Amerigroup Service Coordination: 913-749-5955, ext.106-103-5178 or kscasespec@amerigroup.com
AIRS link: https://webapps.kdads.ks.gov/LSOBP18/f?p=199:15::::15

PEAK program

For the past 10+ years, KDADS has been recognizing nursing homes for successfully implementing culture change through the Promoting Excellent Alternatives in Kansas Nursing Homes program, commonly known as PEAK. From the beginning of PEAK, KDADS pursued two primary goals.

- First, the agency presented annual awards to homes that accomplished significant culture change (http://kdads.ks.gov/about-kdads/the-commitment-to-culture-change-in-kansas-adult-care-facilities).
- Second, KDADS worked to educate others about the culture change movement and the accomplishments being made in Kansas.

PEAK program (cont.)

Beginning in 2012, PEAK expanded from a recognition program to a pay-for-performance Medicaid program in am effort to speed up the rate of adoption of person-centered care practices in Kansas nursing homes. The program had an overwhelming response, with 125 homes enrolling in PEAK 2.0 the first year. It was unexpected that such a large number of participants would get involved, so KDADS quickly arranged a partnership with the Kansas State University (KSU) Center on Aging to administer the program. To date, 165 homes are actively involved in the program.

Link: http://kdads.ks.gov/commissions/survey-certification-and-credentialing-commission/peak

PEAK program (cont.)

In order to meet the educational objectives of the original PEAK awards program, KDADS contracted with KSU to produce educational materials to assist nursing homes. KSU has produced several booklets that address different areas of culture change. These booklets have been distributed to all Kansas nursing homes and other parties involved in the nursing home profession. The booklets were the starting point for educating our state on culture change. The program continues to evolve. New program information is available at the KSU Center on Aging website. To learn more, visit:

http://www.he.k-state.edu/aging/outreach/peak20.

PEAK program (cont.)

- **Activities:**
  - Activity Module Part 1
  - Activity Module Part 2
- **Community Module**
- **Creating Home:**
  - Creating Home Module Part 1
  - Creating Home Module Part 2
- **Culture Change**:
  - Culture Change Module Part 1
  - Culture Change Module Part 2
- **Dementia**
- **Dining:**
  - Dining Module Part 1
  - Dining Module Part 2
- **Diversity Module**
- **End-of-Life Care Module**
- **Family and Community Module**
- **Leadership Module**
- **Measuring Change Module**
- **Spiritual Needs Module**
- **Returning Control to Residents Module**
- **Sexuality Module**
- **Staff**
  - Strengthening Staff Module Part 1
  - Strengthening Staff Module Part 2

Service coordination model

- Our service coordination model promotes cross-functional collaboration in the development of member service strategies.
- We recognize members have complex needs and often:
  - Require services from multiple providers.
  - Experience gaps in the health delivery system.
  - Encounter barriers to receiving needed care.
- The scope of the service coordination model includes annual assessments to identify member needs, including:
  - Annual assessments.
  - Initial and ongoing assessments.
  - Problem-based comprehensive service planning.
  - Coordination with PCPs and specialists.
  - Offering a member-centric approach.
  - Personalized plans to meet the specific needs of the member.
  - Obtaining family and caregiver participation.

Service coordination model and discharge planning

- We assist with discharge planning, including transfers to other facilities.
- For members requesting a discharge to the community, our service coordinator will:
  - Collaborate with the nursing facility staff.
  - Facilitate a home visit to the residence.
  - Coordinate a discharge planning meeting.
  - Collaborate with community organizations as needed.
  - Finalize and execute the transition plan.
- Any transitions and discharge planning is a joint effort between the Amerigroup service coordinator and the nursing facility staff. It is the nursing facility's responsibility to collaborate with the service coordinator.

Transitional services

Transitional services allow residents to repatriate out into the community via HCBS.

- To be eligible for this program, members must:
  - Be in a current institutional setting such as a nursing facility, state hospital (Parsons and KNI), ICF/IDD or PRTF with a minimum stay of 90 consecutive days.
  - Meet the functional eligibility for waivered services.
  - Have an interest in transitioning back into the community.
- **All transitional services require PA and are *in lieu of services*.**
- Services offered under the transitional program include:
  - Waiver services (FE, PD, TBI and IDD).
  - Transition funds (HCPCS H2016 U3) — up to $2,500.
  - Transition coordination services (HCPCS H2015 U3) lifetime limit of 192 units.

Claims submission procedures

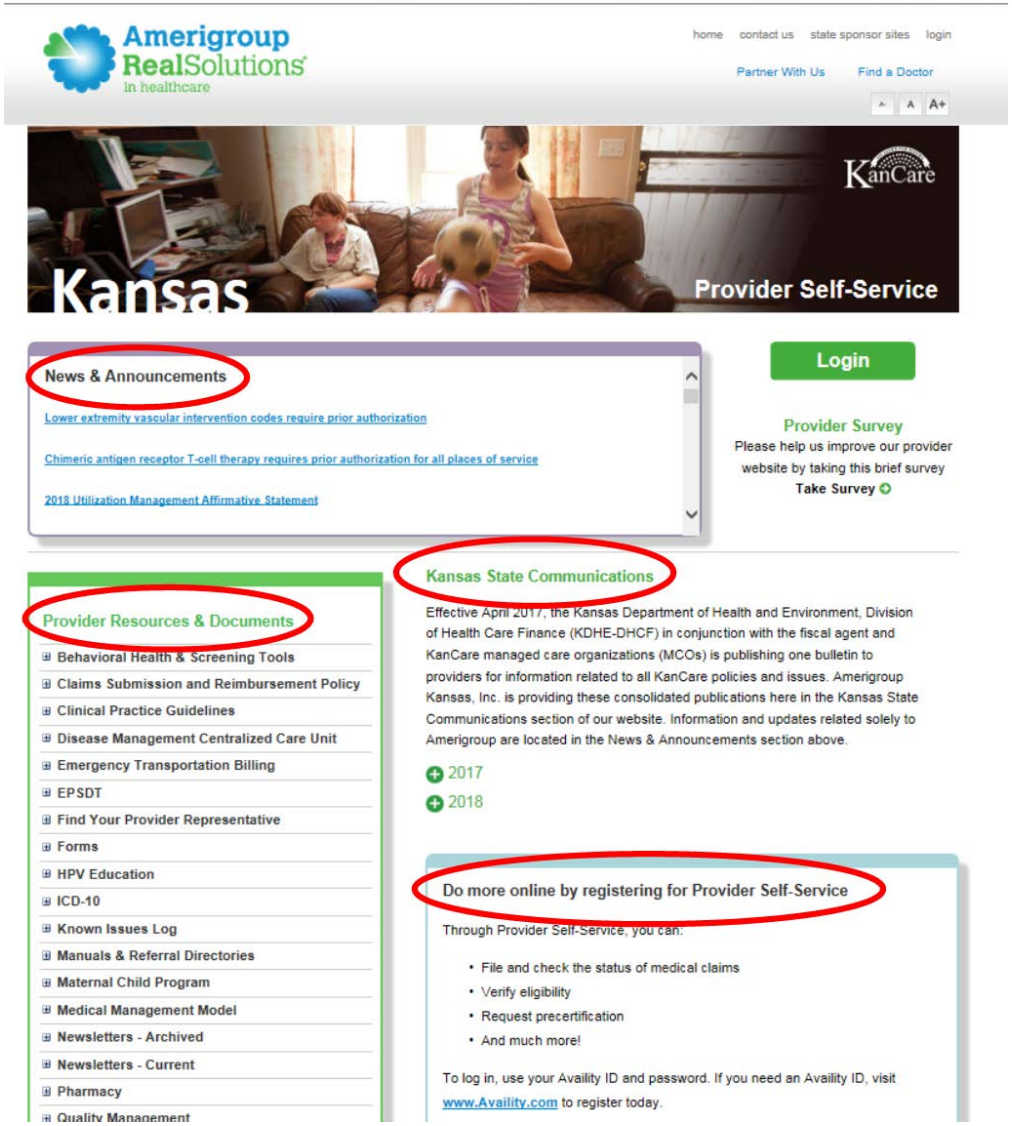
Amerigroup offers several options for providers to submit claims:

- KMAP
- Availity
- Clearinghouses:
  - Emdeon payer ID 27514
  - Capario payer ID 28804
  - Availity payer ID 26375
- Paper claims:

  Amerigroup Kansas, Inc.

  P.O. Box 61010

  Virginia Beach, VA 23466



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Value-added benefits available to nursing facility/swing bed members

Healthy rewards

- Members can use points to buy fun and healthy items from our rewards catalog. Points are earned when members get well-child checkups, mammograms, cervical cancer screenings, flu shots, diabetic screenings, refills of medication used to treat schizophrenia, refills of medication used to treat asthma or the step-up challenge.

Adult preventive dental care

- Two cleanings annually
- Scaling and polishing procedures to remove coronal plaque, calculus and stains

Adult podiatry

- Adult members may receive four podiatry visits per year with diagnosis of diabetic neuropathy and/or peripheral vascular disease

Mail-order over-the-counter pharmacy

- $10 member monthly allowance toward the purchase of over-the-counter products via a secure website

Amerigroup contact information for providers

For Provider Relations inquiries such as demographic updates, credentialing or contracting, please call our Kansas Provider Relations team at 1-877-434-7579, ext. 106-134-5011.

For claims inquiries, you may call the Amerigroup National Provider Services team at 1-800-454-3730 or log in to our secure website at https://providers.amerigroup.com.

Nonparticipating nursing facility authorization requests: kscasespec@amerigroup.com

Service coordination: 913-749-5955, ext. 106-103-5178 or kscasespec@amerigroup.com

Link to *Provider Relations Consultant Territory Map*:
https://providers.amerigroup.com/ProviderDocuments/KSKS_ProviderTerritoryMap.pdf

KanCare

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Slide reference information

- Slide 3 — CARE assessments: https://www.kdads.ks.gov/provider-home/care-provider-information
- Slide 4 — *Quick Fax Sheet*: https://www.kdads.ks.gov/images/default-source/CARE/care-quick-fax-sheet.jpg
- Slide 6 — *MS-2126 Form*: http://www.kancare.ks.gov/docs/default-source/policies-and-reports/KDHE-KEESM/KFMAM-Medical-Forms/external-forms/ms-2126-4-18.pdf
- Slide 12 — KMAP logon: https://www.kmap-state-ks.us/PROVIDER/SECURITY/logon.asp
- Slide 30 — Amerigroup service coordination contact: 913-749-5955, ext.106-103-5178 or kscasespec@amerigroup.com
- Slide 30 — KDADS AIRS link: https://kdads.ks.gov/provider-home/providers/adverse-incident-reporting
- Slide 31 — KDADS PEAK: http://www.kdads.ks.gov/commissions/survey-certification-and-credentialing-commission/peak
- Slide 32 — K-State PEAK: http://www.he.k-state.edu/aging/outreach/peak20
- Slide 35 — *Opioid PA Criteria*: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- Slide 35 — *Opioid PA Form*: http://www.kdheks.gov/hcf/pharmacy/pharmacy_class_specific_clinical_pa_forms.htm
- Slide 37 — Amerigroup provider website: https://providers.amerigroup.com
- Slide 39 —*Kansas Provider Relations Territory Map*: https://providers.amerigroup.com/ProviderDocuments/KSKS_ProviderTerritoryMap.pdf

Thank you!