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F-1 Regular Medicaid Services (*State Plan services*)

The following services are available to eligible individuals who receive Medicaid. However, these services are paid for under the Kansas Medicaid State Plan, and not with HCBS/TBI waiver dollars.

a. Pharmacy

Most prescribed medications and supplies are covered. Some medications need prior authorization. Over-the-counter medications or supplies may also be covered when prescribed.

b. Home Health/Skilled Nursing & Therapy

Skilled nursing care, home health aide care, and certain therapies may be covered. When ordered by a medical provider, therapies such as physical, occupational, and speech must be rehabilitative, restorative, and received within six months of the related accident or illness. A maximum of six months is covered for these therapies under Medicaid state plan services.

Please note that this does not include the broad range of therapies offered under the HCBS/TBI waiver (such a behavioral or cognitive therapy). If the individual is eligible for therapy under the state plan, the therapy should be paid for first through their regular Medicaid, and then can be paid for under the waiver after their state plan coverage has been terminated.

**Home health aide services and skilled nursing care require prior authorization once the consumer is receiving HCBS.*

c. Durable Medical Equipment

The individual must need this service for school, employment, life support, or to avoid other more costly care. Rental and purchase of medical equipment/devices must be medically necessary.

d. Transportation

- i. Ambulance - Emergency situations where lack of immediate medical attention places the consumer's health in jeopardy, seriously impairs bodily functions, or results in serious dysfunction of a body organ or part. Also non-emergency situations when a car or van cannot be used. Medical necessity must be documented.

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- ii. Commercial & Non-Commercial Non-Emergency Medical Transportation- (NEMT—formerly referred to as NAMT) is covered when provided for medical purposes for Medicaid consumers. Transportation is only covered when an eligible Medicaid consumer is in the vehicle.

General NEMT Requirements

- (1) Non-emergency medical transportation (NEMT) is covered for Medicaid consumers for medical purposes only and when no other less expensive mode of transportation is available.
- (2) Medical consumer must be transported in the vehicle.
- (3) The least expensive means of transportation (appropriate to the consumer’s medical need) must be used.
- (4) Transportation is available for services received within the state of Kansas or within 50 miles of the Kansas border provided that the consumer is traveling to the closest available provider for their medical condition. Reimbursement will not be made if the consumer chooses to travel to another community for the same service.

NOTE: Reimbursement of transportation shall only be made if the consumer is receiving a medical service from the closest available provider.

- (5) Transportation must be provided by an enrolled transportation provider in accordance with Medicaid rules and transportation manual guidelines.
- (6) Emergency AMBULANCE transportation is the ONLY transportation service covered for MediKan consumers.
- (7) Medically necessary transportation services will be covered for consumer receiving hospice services.

- a) Non-Commercial NEMT- provided by family members, friends, etc. requires prior authorization from the local SRS office before providing the trip. The driver must apply for a provider number through the fiscal agent to be reimbursed, and should be prepared to offer their driver’s license and other pertinent information to qualify.

- b) Commercial transportation (cab, van, etc.)- may be obtained by calling Medicaid commercial providers directly. Individuals requesting this service must meet Medicaid guidelines.

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e. Targeted Case Management

Medicaid-eligible individuals, 16-65* years of age, who meet criteria for TBI Rehabilitation Facility placement as determined by a qualified TBI Targeted Case Manager (TBI-TCM), shall be eligible for this service if they do not have another Medicaid-funded Case Manager or Independent Living Counselor. Targeted Case Management is a Medicaid State Plan service and can be provided before and after waiver services if the individual is assessed and meets criteria on the TBI-UAI & Addendum and is Medicaid eligible. This is a required waiver service under K.A.R. 30-5-78.

**Individuals who turn age 66 while on the HCBS/TBI waiver and continue to show increased independence and benefit from rehabilitation may continue to receive waiver services with special approval from the TBI Program Manager.*

The scope of Medicaid Targeted Case Management for individuals who have sustained a Traumatic Brain Injury includes seven components defined as follows:

- i. Assessment/Reassessment/Plan of Care Development/Transition Plan
 - (1) A comprehensive review of the medical needs, social needs, psychological needs, functional capabilities, current services received through formal and informal sources, evaluation of environment, available financial resources.
 - (2) Reassessment is the periodic review as needed, but done at least annually.
 - (3) Development of a Plan of Care an individualize agreement between the individual receiving services or legal representative and the TBI-TCM. The POC is based on: identified needs, goals, and preferences of the individual within cost restraints.
 - (4) Development of a Transition Plan, updated at least annually.
- ii. Service Coordination and Implementation
 - (1) The TBI-TCM coordinates the essential services with the consumer.
 - (2) Coordinates with service providers and other agencies.
 - (3) Initiate contacts and/or conferences with the individual and/or his/her legal representative, providers, and others as agreed to by the consumer.

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iii. Monitoring and Quality Assurance

- (1) Visits with the individual on a regular basis.
- (2) Confers with other providers as needed to assure appropriate and sufficient services are being provided to meet the needs, preferences and goals of the consumer.

iv. Resource Development

- (1) Optimal integration of funding sources.
- (2) Care plans are flexible and reflect a proactive orientation.
- (3) Challenge the formal service system to be more flexible and to accommodate consumer values and preferences.
- (4) Removal of obstacles which impede or limit the delivery of services.

v. Gatekeeping

- (1) Efficient use of public and private resources to meet consumer needs and preferences.
- (2) Involves at a minimum:
 - a) determining the comparative costs of alternative care plan options;
 - b) calculating the private as well as public costs of provider services;
 - c) monitoring service expenditures over time; and
 - d) advocating for the consumer in accessing the provider preference and delivery system of choice.

vi. Documentation

- (1) Accurate record keeping to include contacts with consumers, family members, service providers or other interested parties.
- (2) Provide assurances of appropriateness of services.
- (3) Provide the necessary detail to meet federal and state requirements as an audit trail.

vii. Advocacy

- (1) Advocate on both an individual and system level.
- (2) The TBI-TCM is acting on behalf of a person or encouraging the individual to act on his/her own behalf.

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viii. Limitations

- (1) Caseload is limited to a range of 20-30 consumers per TBI-TCM.
- (2) Providers of this service may not provide other direct services to the individual for whom they provide case management. TBI-TCMs *may* provide TLS, if qualified, to individuals for whom they are not providing case management services.
- (3) This service should not be provided in conjunction with any other Medicaid case management service unless authorized.
- (4) Limited to individuals with the traumatically acquired head injuries who meet TBI Rehabilitation Facility criteria and are Medicaid eligible.
- (5) Persons with familial relationships to the individual with the brain injury may not provide the case management services.
- (6) A maximum of 160 hours per individual, per year, is allowable.
- (7) This is a mandatory service under K.A.R. 30-5-78.

ix. Providers

- (1) Have at least six months' experience with a disability as recognized by the Rehabilitation Act of 1973; or
- (2) At least one year professional experience providing direct services including case management (working directly with people with a variety of disabilities); and
- (3) An understanding of Independent Living philosophy with at least twelve hours of standardized training in history and philosophy of Independent Living every year provided by a Center for Independent Living or the State Independent Living Council of Kansas; and
- (4) Completion of a standard practicum which includes "on-the-job" training of at least four assessments with monitoring provided by at least two different qualified TCMs already trained and or more assessments completed solely by the trainee with supervision provided by a qualified TCM; and
- (5) A total of 40 hours training regarding TBI; and
- (6) On an annual basis, demonstration of proficiency about the services, policies, rules and procedures of the HCBS/TBI program. This is an agency responsibility and should be recorded in the TCM's personnel file.

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F-2 HCBS/TBI Waiver Services

a. Personal Services

Personal Services means one or more persons assisting another person with a disability with tasks which the disabled individual would typically do for themselves in the absence of a disability. Such services may include, but are not limited to, assisting consumers in accomplishing daily routines and lifestyle choices. Examples include combinations of assistance to get ready for work or school; to clean house; to shop; or get ready for bed; transportation; bathing; grooming; toileting; transferring; feeding; mobility; accompanying to obtain necessary medical services; house cleaning; meal preparation; laundry; and life management.

Health Maintenance Activities (HMAs) such as monitoring vital signs, supervising and/or training others on nursing procedures, ostomy care, catheter care, enteral nutrition, assistance with or administering medicines, wound care, and range of motion may be provided when they are delegated by a Physician or Registered Nurse and are documented in the Plan of Care, in accordance with K.S.A. 65-6201(b)(2)(A). A form for the delegation of such duties is included in Section Q. of this manual.

All Personal Services will be arranged for and authorized by the TCM with the individual's written authorization of the purchase. Consumers will have complete access to choose any qualified provider who can meet their Personal Service needs. Only agencies may enroll to provide this service. Individual providers of these services must affiliate with a recognized independent living center as defined in K.S.A. 65-5101 (e), or licensed home health agency as defined in K.S.A. 65-6201. Certain family members may be reimbursed when providing these services. However, under no circumstance will parents of minor children or spouses be paid (with exceptions made under K.A.R. 30-5-307 – see below).

Reimbursement for these services is limited to the individual's assessed level of services needed. This service must be reimbursed within the approved reimbursement range established by the state.

i. Providers of Personal Services

Individual's receiving services have the right to choose who provides their Personal Services (within established guidelines). This includes the option to self-direct their care or choose a Home Health Agency to provide staff to complete the tasks on the plan of care.

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(1) Spouses or parents of minor children as providers-

Certain family members cannot be reimbursed for providing assistance with ADLs or IADLs (includes employees of HHAs). Federal Medicaid regulation 42 CFR 440.167 states that legally responsible family members (spouses or parents of minor children) cannot provide personal care services unless they meet specific, approved criteria. Exceptions to the family reimbursement restrictions are set out in K.A.R. 30-5-307.

**Legal, adjudicated guardians may provide Personal Services under the TBI waiver, however, this allowance in no way supercedes the family reimbursement restriction.*

(2) Time sheets & signatures-

The file regarding services for the individual must be legible and stand on its own. Documentation for the HCBS program shall include at a minimum the use of a timesheet to validate services were provided. Each visit, at minimum, should include the date, time started/stopped, attendant's name and signature, and the consumer's or their legal representative's signature or individual "mark." Specific documentation requirements can be found in the provider manual published by the fiscal agent.

b. Transitional Living Skills

Transitional Living Skills (TLS) are provided by a trained TLS Specialist who assists the individual with a brain injury to learn the skills necessary to be independent. Training in such daily living skills may include, but are not limited to, cooking, bathing, grooming, social skills, and managing medical needs. These services may be provided (based on assessment) up to four hours a day (16 units), seven days a week, with a maximum of 3120 units per year. A minimum of five hours (20 fifteen-minute units) a week should be included on the POC (consideration will be given to individuals when they are ill or cannot complete the five hours due to unforeseen circumstances). A TCM may not provide TLS to an individual if they are serving in the capacity of case manager for that individual.

A person *must* be receiving transitional living services to obtain and/or remain on the HCBS/TBI Waiver. This is a required waiver service under K.A.R. 30-5-78. If TLS cannot be provided within 60 days from the start of services, or if there is a lapse in TLS for more

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than 60 days during the period the individual is receiving HCBS/TBI Waiver services, the individual's case must be transferred to an agency that can provide TLS in a timely manner, transferred to another waiver (if appropriate), or the case must be closed.

TLS are comprehensive in nature, and should therefore address multiple aspects of an individual's needs and goals to achieve as much independence as possible in a variety of skill areas. The Targeted Case Manager should include TLS support on the Attendant Care Worksheet. Whenever possible, the Personal Service provider should supplement the work of the TLS (such as prompting to use journals, medication reminders, etc.).

It is imperative that the TLS Specialist and the TCM communicate on a regular basis. TCMs should be kept aware of such things as physical complaints, emotional and behavioral problems, as well as successful strategies that the TLS have found to implement a goal and any improvement seen in the person's daily functioning. Team meetings and communication logs (if approved by the consumer) are an excellent way to make sure everyone (including personal assistants and therapists) is working toward the same end. Reimbursement for overlapping services (i.e., team meetings in which several providers wish to be reimbursed for the same time span) must be approved in writing by the TBI Program Manager.

- i. TLS Specialist Qualifications- Individuals who provide Transitional Living Skills (TLS) under the HCBS/TBI Medicaid waiver are required to be trained by the HCBS/TBI waiver provider for whom they are employed by using the SRS/HCP/Community Supports and Services TLS training manual. The TLS Specialist candidate must complete the test that accompanies each module of the manual at a comprehensive level of 80% correct answers.
- ii. The HCBS/TBI waiver provider is responsible for reviewing the tests and ensuring that they have been successfully completed. The provider must then submit a form which should be used to notify the TBI Program Manager of a TLS Specialist candidate's successful passage of the certification tests (see Section Q. of this manual for copy of form).
- iii. Individual TLS Specialists must receive 28 hours of training as is written in the HCBS/TBI waiver document. This mandatory curriculum is a basis for the required 28 hours of training.
- iv. The TLS Training Manual is available on-line in PDF at: <http://www.srskansas.org/hcp/css/HIPPPManual.html>. The appendices, however,

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are not available on-line due to size considerations. Each TBI Waiver provider is provided with an original of the manual to copy and distribute at their discretion.

**The TCM should be familiar with the contents of the TLS manual in order to appropriately guide the TLS Specialist. The preferred 'best practice' would be that the TCM completes the TLS training.*

c. Assistive Services

Assistive Services are those services which meet an individual's assessed need by modifying or improving an individual's home and through provision of adaptive equipment. Cost-effectiveness should be considered along with other factors, including quality of life, and level of independence when including Assistive Services in a Plan of Care.

Purchase or rent of new or used tangible equipment or hardware under the definition of this service limited to those items not covered through regular Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation or Educational System). This service will be used only as the funding source of last resort. Tangible equipment or hardware requires prior authorization from the TBI Program Manager.

Examples of Assistive Services:

- Ramps
- Lifts
- Modifications to bathrooms and kitchens specifically related to accessibility
- Specialized safety adaptations
- Assistive technology that improves mobility or communication

Environmental modifications may only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years and will give first rent priority to tenants with physical disabilities.

i. Reimbursement

Reimbursement for this service is limited to the individual's assessed level of services based on the Plan of Care. All Assistive Services will be arranged by the TCM with written authorization from the individual receiving the service. Individual's may choose any qualified provider, but should be the most economical to meet the individual's needs. If the qualified provider does not

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wish to contract with the case management agency, the state shall provide a separate provider agreement by means of the Fiscal Agent, allowing the provider to request reimbursement directly.

ii. Limitations

The maximum lifetime expenditure on Assistive Services is \$7,500 per individual. Those persons who have received a similar service previously on the HCBS/PD or HCBS/MRDD waivers must deduct the amount of the previous Assistive Service from the lifetime maximum of \$7,500 to determine the amount which may be available to the consumer under the HCBS/TBI Waiver. However, special consideration to waive this amount may be given by the TBI Steering Committee's Administrative Review Team.

iii. Enrollment

Providers of this service are contractors arranged for through the Case Management Agency or Durable Medical Equipment providers meeting the standards set forth in K.A.R. 30-5-108. Contractors must be licensed according to local and county codes in which they work. Providers of Durable Medical Equipment must be enrolled vendors with SRS, meeting standards set in K.A.R. 30-5-108.

iv. Plan of Care

Assistive Services must be approved by the TBI Program Manager. The request should be submitted to the TBI Program Manager and include the cost of reimbursement with supporting documentation (e.g., catalog price list, estimate from DME provider) and the reason for the request (must support the individual's goals and increased independence). The TBI Program Manager will approve or deny the request in writing. If approved, the service may then be added to the POC and sent for approval via the MMIS Prior Authorization System.

d. Sleep Cycle Support

This service provides non-nursing physical assistance and/or supervision during the consumer's normal sleeping hours in the consumer's place of residence. This assistance includes (but is not limited to): 1) physical assistance or supervision with toileting, transferring, turning, liquids, and mobility, and 2) prompting and reminding of medication.

Providers will sleep and awaken as identified on the consumer's service plan and must provide the consumer with a mechanism to gain their attention or awaken them at anytime.

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Providers must be ready to call a physician, hospital, or other medical personnel should an emergency arise.

- i. Providers must be at least 18 years of age.
- ii. The period of service must be at least 8 hours in length, but cannot exceed a twelve-hour period. One unit is allowed within a 24 hour period.
- iii. The plan of care must indicate a need for this service that is beyond the need for a Personal Emergency Response System (see 'e.' below).
- iv. Providers must submit a report to the case manager within the first business day following any emergency response provided.
- v. Individual providers, not affiliated with an agency, must be enrolled through a Center for Independent Living or Home Health Agency.

e. Personal Emergency Response Systems (PERS)

PER Systems are electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the "help" button is activated. PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular attendant (formal or informal) for extended periods of time, and who would otherwise require extensive routine supervision.

- i. Limitations
 - Maintenance of rental equipment is the responsibility of the provider
 - Repair/replacement of equipment is not covered
 - Rental of the PER System is covered, purchase is not
 - Call lights do not meet this definition

f. PERS Installation

The HCBS/TBI waiver allows for a maximum of two PERS Installation's per year (generally due to the individual moving or losing phone service for a period of time).

g. Rehabilitation Therapies

The primary purpose of Rehabilitation Therapies is to provide in-home services for individuals who have sustained a traumatic brain injury who would otherwise require placement in a TBI rehabilitation facility. These therapies are designed to prevent, maintain, and/or minimize chronic disabilities while restoring the individual to the optimal level of physical, cognitive, and behavioral functions within the context of the community.

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Rehabilitation Therapies offered under the HCBS/TBI waiver are only those services not available under State Plan Medicaid funding. Physical Therapy, Occupational Therapy, and Speech-Language Therapy are paid for by the State Plan if they are provided within a maximum of six months from the date of the first treatment following a physical debilitation resulting from acute physical trauma or physical illness. Services extending into the seventh month are not covered by general Medicaid funds from the State Plan. Since many individuals with head injuries need Rehabilitative Therapies well beyond the six months that general Medicaid provides, these therapies have been included in the HCBS/TBI waiver so individuals may maintain skills they have learned through therapy. When possible, the six months of State Plan covered therapy should be used first, before adding those therapies to the POC.

Rehabilitation Therapies are designed to improve the skills and adjustment of the person with a brain injury, and integrate pre-vocational, educational, and independent living goals in order to return or maintain the individual's most optimum level of functioning and least restrictive level of care. These services may not be subcontracted by providers of TLS or any other service offered under the HCBS/TBI waiver. Therapies must be provided by licensed individuals who meet specific requirements. There is a limitation of 3744 15-minute units of combined therapies per year.

All therapies may be provided under the supervision of the enrolled, licensed provider. Documentation requirements can be found in the individual provider manuals published by the Fiscal Agent.

i. Physical Therapy

A Physical Therapist (PT) works to assist the person with a brain injury to reach their highest level of motor functioning and mobility. This may involve intensive work in a variety of areas including standing, sitting, walking, balance, muscle tone, endurance, strength, and coordination. The PT assesses and treats the areas of strength, range of motion, balance, positioning, walking, or wheelchair mobility. The PT also identifies special equipment that the individual can use and teaches them how to use it. If an individual uses a wheelchair, they may teach them to assemble and use it properly. They may also teach the individual the correct way to get in and out of the wheelchair.

Physical Therapists must be licensed by the Kansas Board of Healing Arts. Physical therapy services may be provided by a licensed Physical Therapist or by

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staff members that are supervised by a licensed PT.

ii. Speech Therapy

The Speech-Language Pathologist is responsible for the diagnosis and treatment of communication disorders. Assessment and treatment may include the areas of language (i.e., listening, talking, reading, writing) cognition (i.e., attention, memory, sequencing, planning, time management, problem solving), motor speech skills, and conversational skills. A screening of hearing acuity is also sometimes performed in the initial assessment.

A Speech-Language Pathologist evaluates and treats challenges in the areas of speech production, language expression, comprehension, reading, writing, and even swallowing. The Speech-Language Pathologist may work with the individual to improve such things as attention, memory, abstract reasoning, and decision making. They may also work on social skills such as how to appropriately participate in a conversation.

This therapy must be provided by a Speech Pathologist who is licensed by the Kansas Department of Health & Environment. They must also have eight (8) hours of training or one year experience, and expertise in brain injury rehabilitation.

iii. Occupational Therapy

An Occupational Therapist's (OT) role is to help the individual regain the physical, perceptual, and cognitive skills needed to perform activities of daily living such as self-care, home maintenance, and community skills. The OT evaluates an individual's balance, motor skills, posture, and perceptual and cognitive abilities within the context of functional, everyday activities. Adaptive devices may be recommended by the OT to help the individual achieve the maximum level of independence. OTs often work with other therapists on feeding and swallowing programs. They may also design or obtain special equipment to help the person with specific daily living skills that they cannot do by themselves. Examples of this are large-grip silverware if regular silverware is unsuccessful, or long-handled aids to help them dress themselves.

This service must be provided by an Occupational Therapist (OT) who is licensed

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by the Kansas Board of Healing Arts.

iv. Behavioral Therapy

Behavioral therapy is a psychological technique based on the premise that specific, observable, maladaptive, badly adjusted, or self-destructing behaviors can be modified by learning new, more appropriate behaviors to replace them. In behavioral therapy, people learn how to change behavior.

Behavioral therapy can be a useful treatment tool in an array of mental illnesses and symptoms of mental illness that involve maladaptive behavior, such as substance abuse, aggressive behavior, anger management, eating disorders, phobias, and anxiety disorders. It is also used to treat organic disorders such as incontinence and insomnia by changing the behaviors that might be contributing to these disorders.

This service can only be provided by a Behavioral Therapist (BT) who is licensed by the Kansas Behavioral Sciences Regulatory Board. They must also possess a Master's degree in Social Work or Psychology.

v. Cognitive Therapy

Cognitive therapy is a psycho-social therapy that assumes that faulty cognitive or thought patterns cause maladaptive behavior and emotional responses. The treatment focuses on changing thoughts in order to adjust psychological and personality problems.

In contrast to other forms of psychotherapy, cognitive therapy is usually more focused on the present, more time-limited, and more problem-solving oriented. Indeed, much of what the person does is solve current problems. In addition, individuals learn specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors.

This service can only be provided by a Cognitive Therapist (CT) who is licensed by the Behavior Sciences Regulatory Board. The CT must possess a Master's degree in the behavioral science field who has eight (8) hours of training or one year of experience working with people who have brain injuries.

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vi. Drug and Alcohol Therapy

In drug and alcohol therapy individuals address issues of motivation, build skills to resist alcohol and drug use, replace alcohol and/or drug-using activities with constructive and rewarding non alcohol and drug-using activities, and improve problem-solving abilities. To be effective, treatment must address the individual's alcohol and/or drug use and any associated medical, psychological, social, vocational, and legal problems. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

This service can be provided by Community Mental Health Centers or Drug and Alcohol Abuse Centers. Individuals who provide this service must have a Master's degree in a behavioral sciences field and have eight (8) hours of training or one year experience working with people who have brain injuries.