

Medical procedures

Correct Medicaid Health Care Finance Administration (HCFA) and Current Procedural Terminology (CPT) codes are used to determine the amount to be authorized/paid for services, unless otherwise specified. Medicaid payment is payment in full and no additional payment is authorized. Providers shall not request or accept additional payment from clients.

Medical card/other insurance

If the client has a medical card or other medical insurance, either Medicaid or the insurance must be used before Rehabilitation Services (RS) may pay. A Medicaid payment is payment in full and no additional payment may be made. If private insurance pays part of the bill, RS will pay the balance that would be charged the client up to the maximum Medicaid allows for a specific service. Providers shall not bill for any "write-offs."

Payment

The physician or medical provider should provide the services authorized and should notify the counselor if any additional services are to be provided. Although RS may authorize a service by procedure code and description, the medical provider may change the code to indicate services actually provided in accordance with allowable established codes. If the code billed does not appear on Kansas Management Information System (KMIS) either with or without a rate, it is not valid. If the procedure code supplied by the provider allows less than the amount authorized, the lesser amount is paid.

All medical providers should be able to provide the proper procedure code (including modifiers necessary) for services they provide. Staff should not hesitate to request this information. All Kansas physicians and providers should have this information since it is needed to file insurance claims.

Non-covered Medicaid services

KMIS shows the amount Medicaid allows for a specific procedure. If the procedure code shows a blank, zero, seven or nine in the allowed cost, Medicaid does not cover the services or has special requirements. RS staff should verify with the provider that the non-covered Medicaid procedure code is the service actually provided. If the service was actually correct, the RS Central Office should be contacted about the rate.

Substance abuse services

Use the referral process established by SRS Addiction and Prevention Services for inpatient and outpatient substance abuse treatment. See <http://www.srskansas.org/hcp/aaps/ResourceDirectory.html>

Anesthesia

All anesthesia services are paid by points indicated in the surgical procedure code with the modified code "IND" on KMIS. The "IND" number relative value (procedure code plus modifier) plus time in units of 15 minutes are added and multiplied by a conversion factor of \$19.50.

Anesthesia Example: The procedure code of 66984-3000 has an "IND" code of 8 (relative value). If the time used of 121 minutes is divided by the 15 minute unit to determine time points, the time points would equal 9. A partial time unit is considered a full unit. Together the relative units of 8 plus the time units of 9 would equal 17 units times \$19.50.

Medical Report/Definitive- \$20

- A report the physician provides in response to a counselor's request. This report summarizes information rather than copying medical records only.

Medical/Hospital Records- \$10

- RS counselors pay as billed up to a maximum of \$10 for medical records, unless a regional exception has been authorized by the RS Program Administrator.
- Government agencies such as state hospitals, Veterans Administration, etc. usually provide records without charge.
- It is best practice to request only the most recent specific records needed for VR eligibility and planning purposes.

Medical Records Search Fee- \$1.00 per quarter hour or portion thereof.

Payment for health insurance premiums

This is an allowable VR expense, if it is a cost-effective alternative to paying actual medical costs. An analysis of the cost effectiveness and search for comparable benefits must be included in the record of service.