EDS HEALTH COVERAGE PROGRAMS

HCBS Plan of Care Prior Authorization User Manual

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Section One: Introduction

Overview

Welcome to the Kansas Medical Assistance Program's Home and Community Based Services (HCBS) Plan of Care System. The Plan of Care System is used to electronically enter and approve waiver services to allow claims payment. It is accessed through the Kansas Department of Social and Rehabilitation Services (SRS) KMAP website and is used to authorize service. This training material is specifically for the HCBS Waivers.

The Plan of Care system is linked to the electronic eligibility and payment system that is used by Kansas Medical Assistance Program to process claims. Because the systems are linked, the HCBS Plan of Care system can pull information from beneficiary SRS eligibility files. This includes beneficiary name and eligibility, provider names and numbers, procedure code descriptions and pricing.

Once the designated State of Kansas HCBS Approver approves a Plan of Care (POC), the plan will allow claims that fall within the approved plan to be paid. Claims must be submitted according to the Kansas Medical Assistance Program (KMAP) provider manuals for HCBS Waiver Services.

This manual includes instructions for use of the system, helpful tips for using the system, waiver specific information, solutions to common problems, and methods for making changes.

Before Signing On…….

Usually, but not always, the cursor automatically appears in the field in which the User is to start typing.

Buttons will appear on each screen for options such as saving information and exiting the system.

Fields that are shaded cannot be updated and the cursor will not stop in that field.

Once at the Plan of Care screen, remember to either **TAB** or use the mouse to move from field to field. Using the ENTER key may delete data that was just entered.

Section Two: Logging onto the Web Site

KMAP Welcome Window

The only way to access the Plan of Care system is through the Kansas Department of Social and Rehabilitation Services' KMAP website.

Using any Internet server provider, the User will enter the KMAP website address: **https://www.kmap-state-ks.us**

The following window will appear:

For convenience, the User may click on the website address at the top of the window and drag it to their desktop to create a KMAP Icon. This will allow for quick and easy access when going to the website.

Click on **Provider**.

Provider Home Page

A variety of information is available from the Provider Home Page. From this page Users may access:

- Provider Manuals
- Bulletins
- Provider Enrollment forms
- Ancillary Documentation
- Workshop Schedule
- Task Force Meeting Minutes
- The MMIS Login
- Frequently Asked Questions and
- Provider's Rights to Appeal information.

Providers may access this information at any time.

For purposes of using the Plan of Care system, click on **MMIS Login**.

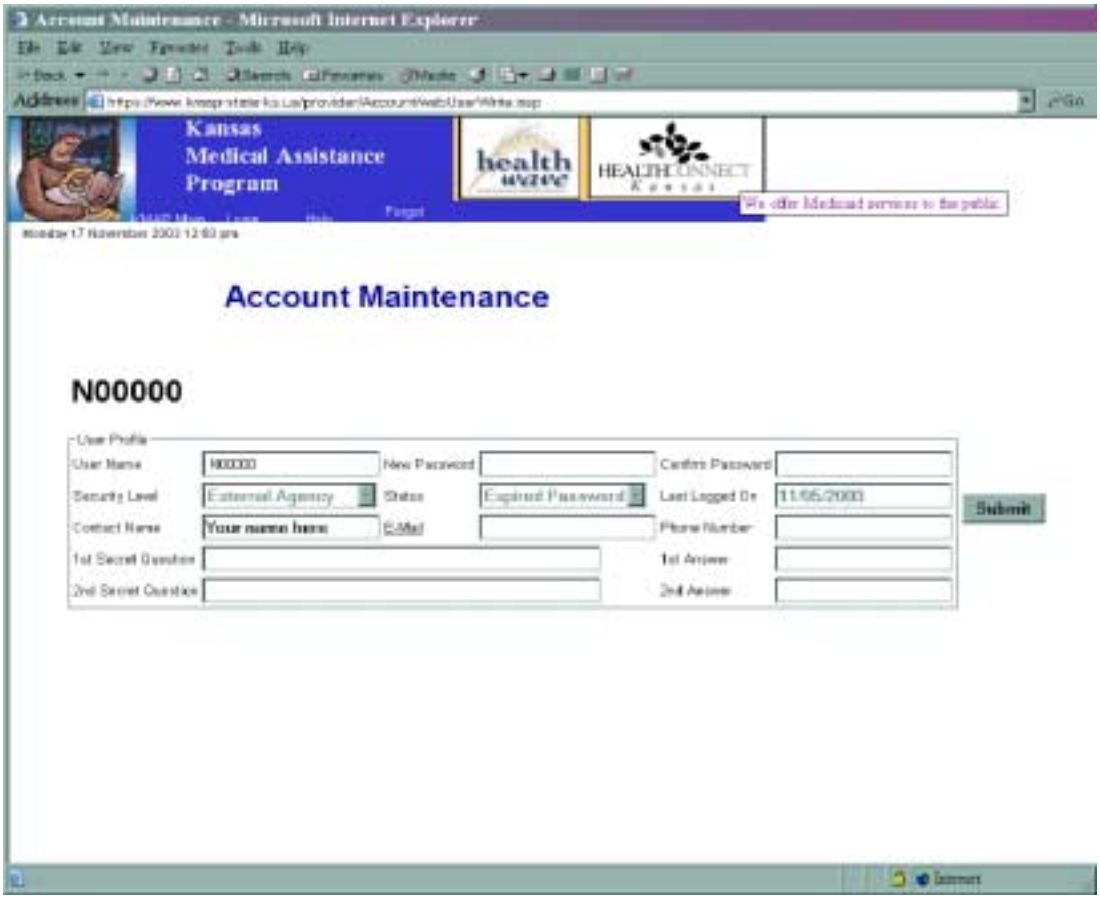
Logon Window

The KMAP Secure Website logon page will appear. If the User has received a User ID and temporary password from the fiscal agent, enter that information in the **Already a Member?** section. The log in ID and password are case sensitive. Use upper case letters for the User ID; lower case letters for the password. If the User has not received a User ID contact the fiscal agent before proceeding.

Once the User ID & password has been entered click on the **Log On** button.

The initial password is a one-time password and the User will immediately be prompted to change their password. Click **OK**.

Account Maintenance



The Account Maintenance window, will allow Users to change their password and update the User ID information.

Click the **SUBMIT** button.

The Mail Box

When the log on sequence is complete, the window above will automatically appear. It will display any new messages received and creates a bulletin board for important messages from SRS. They are informational, read-only messages and are not specific to any Plan of Care.

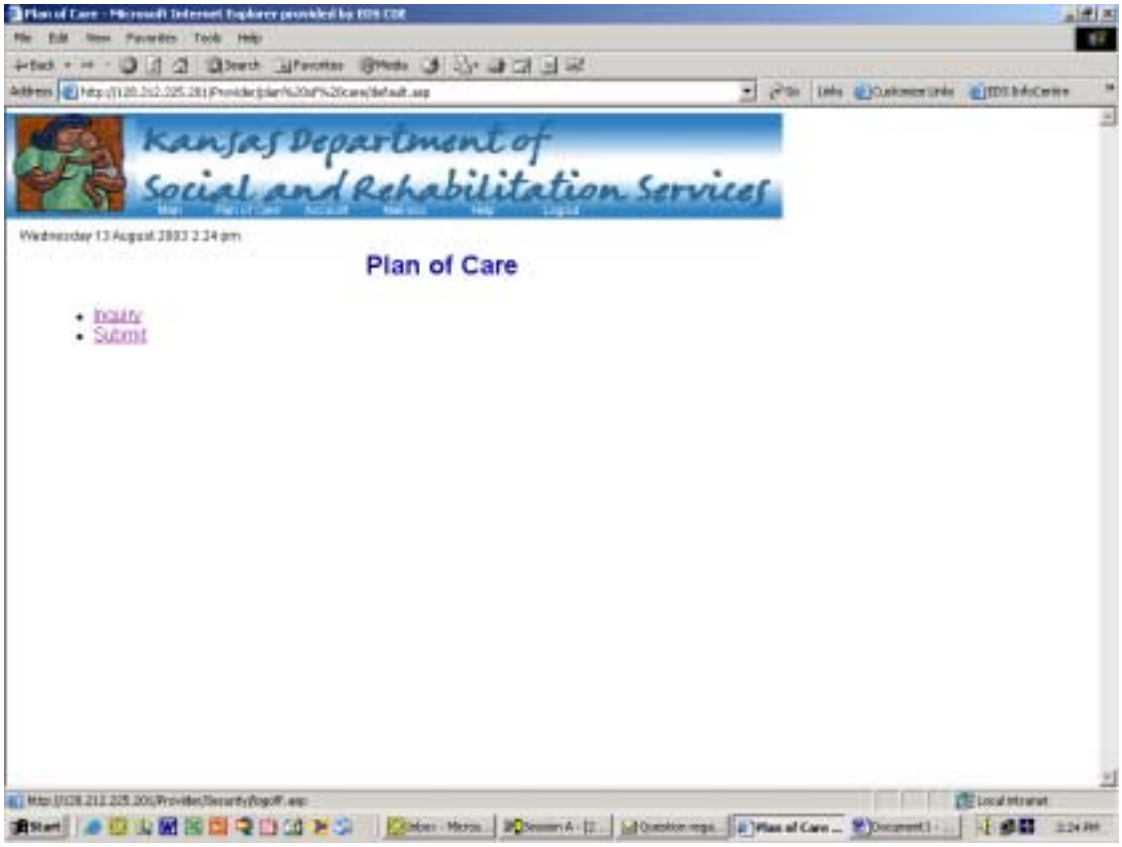
When the **Mailbox** is selected from the menu bar the title of the screen changes to Mailbox with all messages displayed that have not reached the end date.

Click on **Next.**

Notes

Section Three: Submitting a New Plan of Care

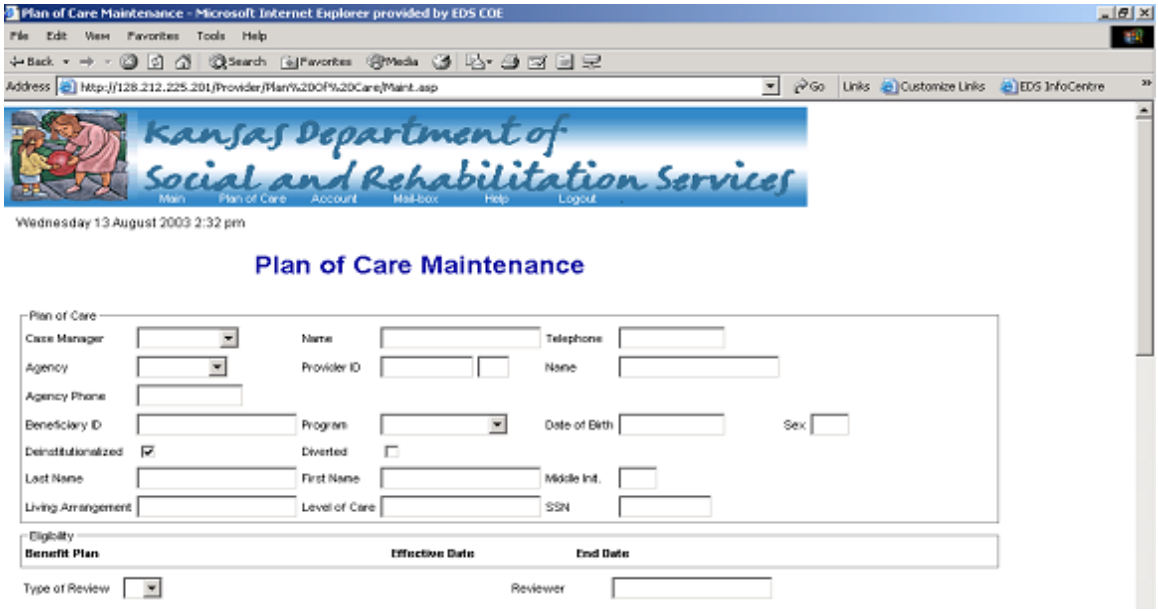
Plan of Care



At the Plan of Care window, Users will click on the **Submit** button.

NOTE: The **Inquire** button will be used for reviewing, changing and updating all existing Plans of Care.
The **Submit** button will be used for all new consumers with new Plans of Care. MRDD Users will also use the **Submit** button when entering an annual Plan of Care.

Plan of Care Maintenance



Please note that User IDs are tied to an Agency Code. Users will be able to access only the Plans of Care that have their Agency's code in the Agency field.

Use the down **arrow** to choose the User ID for this field. Note that the name and telephone field will automatically fill. Future enhancements will include separate fields for data entry staff and case managers.

To select an agency, click on the **down arrow** in the agency field; most agencies will have only one option in this field. These choices are based on the case manager's affiliation with an agency. After choosing the agency, the Provider ID, Name, and Agency Phone will automatically fill.

TAB to **Beneficiary ID** field and enter the number that is listed on the beneficiary's medical card. Tab. Date of Birth, Sex, Last Name, First Name, Middle Init, Living Arrangement, Level of Care, and SSN fields will automatically fill. The eligibility fields will also automatically fill with the correct benefit plan(s) and effective dates. This information comes from the SRS eligibility file. For a description of Benefit Plans, refer to Appendix B.

Note that the cursor is now in the **Program** field, and click on the **down arrow**. Select the assigned HCBS program.

TAB to **Deinstitutionalized** or **Diverted** and check the appropriate box. Diverted is the default setting for this field. Use **Deinstitutionalized** for beneficiaries who were in an institution immediately prior to entering waiver services. This does not include planned brief stays. Use **Diverted** for beneficiaries who are entering waiver services from the community.

TAB to **Type of Review** field, and click on the **down arrow**. Select appropriate type of review: **I** = Initial; **A** = Annual; **R** = Revised.

TAB to the **Reviewer** field, and using the **down arrow**, select the ID of the reviewer to whom it will be routed.

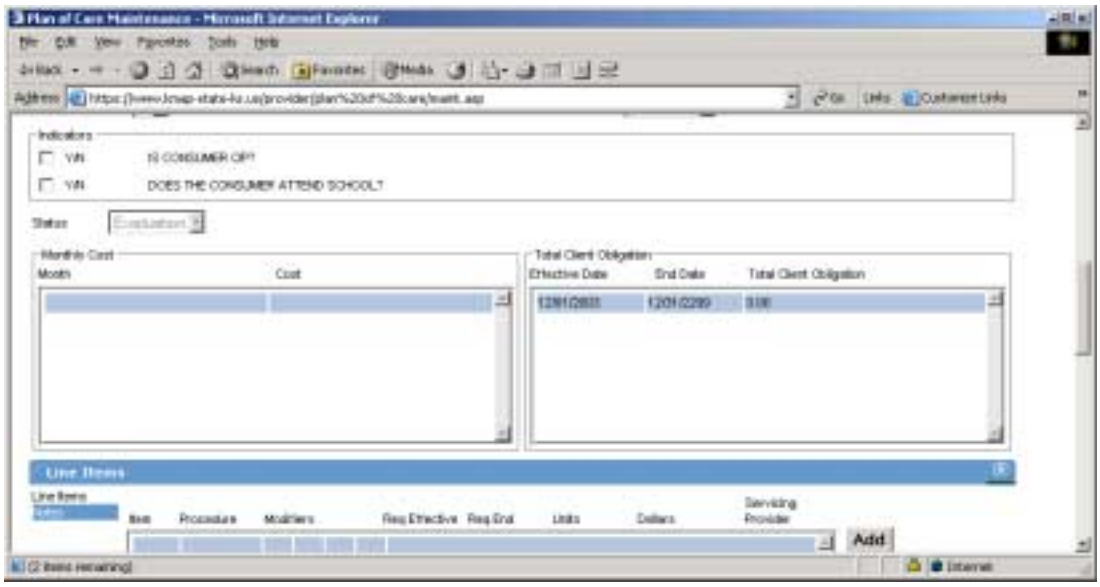
Field Descriptions:

Case Manager	This is the identification number for the case manager assigned to the Plan of Care.
Name	This field auto fills with the name of the case manager assigned to the Plan of Care.
Telephone	This field auto fills with the phone number for the case manager assigned to the Plan of Care.
Agency	This is the code that represents the responsible agency for this Plan of Care.
Provider ID	This field auto fills with the provider ID number corresponding with the responsible agency for this Plan of Care.
Name	This field auto fills with the name of the agency responsible for this Plan of Care.
Agency Phone	This field auto fills with the responsible agency's phone number.
Beneficiary ID	This field represents the identification number for the beneficiary.
Program	This is the assignment code that identifies the waiver program.
Date of Birth	This field auto fills with the beneficiary's date of birth listed on the SRS eligibility file.
Sex	This field auto fills with the beneficiary's sex code listed on the SRS eligibility file.

Deinstitutionalized	This field is checked for beneficiaries who were in an institution immediately prior to entering waiver services.
Diverted	This field is checked for beneficiaries who are entering waiver services from the community.
Last Name	This field auto fills with the beneficiary's last name from the SRS eligibility file.
First Name	This field auto fills with the beneficiary's first name from the SRS eligibility file.
Middle Init	This field auto fills with the beneficiary's middle initial from the SRS eligibility file.
Living Arrgmt	This field auto fills with the Living Arrangement Code from the SRS eligibility file.
Level of Care	This field auto fills with the Level of Care Code from the SRS eligibility file.
SSN	This field auto fills with the beneficiary's Social Security Number from the SRS eligibility file.
Eligibility:	
Benefit Plan	Reference Appendix D
Effective Date	This field represents the start date of the benefit plan.
End Date	This field represents the end date of the benefit plan.
Type of Review	This field represents the type of review **"I"** is initial and is used for the initial Plan of Care for a beneficiary. ("I" will only be used once per beneficiary.) **"A"** is annual and is to used at the regularly scheduled annual re-assessment of the beneficiary. **"R"** is for revised and is to used to make a revision at any time other than the initial or annual Plan of Care.
Reviewer	This field represents the ID of the person that is assigned to review the Plan of Care.

Plan of Care Maintenance Continued

Indicator Questions



Use the scroll bar on the right hand side of the window to scroll to the Indicator questions.

The **Indicator** field will contain questions specific to the waiver program. If the answer to the question is "Yes," click on the box. If the answer to the question is "No," leave the box blank. It is important to always view these questions because they may change.

Note that the **Status** field is gray and is unable to be updated by a case manager. This field is only available to HCBS approvers.

Monthly Cost box will fill as the Plan is completed.

Total Client Obligation box will automatically fill based on information received from the SRS eligibility file. This is the most current information the eligibility worker has entered. You may not have received a notice from the eligibility worker yet because this field updates as soon as the SRS staff authorizes the client obligation change. Further, once it has been updated, all claims will suspend until the new amount is assigned on the Plan of Care.

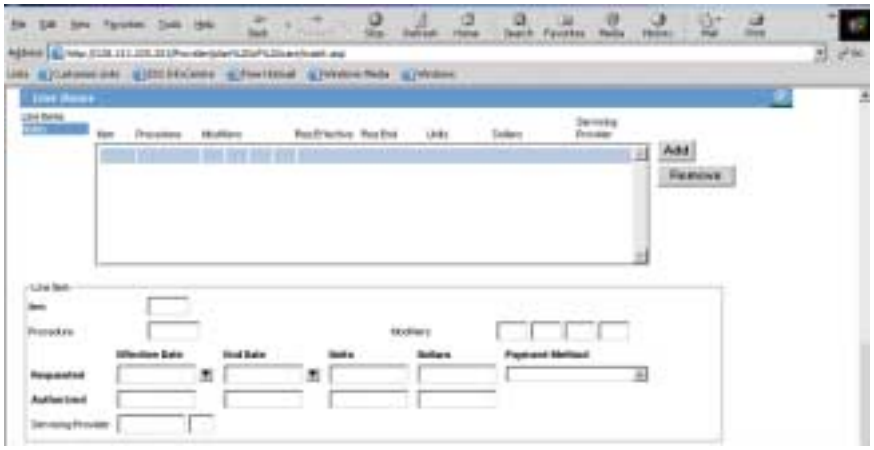
NOTE: It is important to note that when SRS staff updates the Client Obligation in the eligibility files, all claims for that time frame will suspend until the POC is updated with the new Client Obligation.

Plan of Care Maintenance Continued

Field Descriptions:

Indicators	This field represents any questions specific to the selected waiver.
Status	This field indicates the current status of the Plan of Care.
Monthly Cost	This field auto fills with the total monthly cost of the plan.
Total Client Obligation	This field auto fills with the beneficiary's client obligation amount from the beneficiary's SRS eligibility file.

Line Items



To continue moving down the Plan, use the scroll bar on the right hand side of the window and move to the **Line Items** section.

The top box in the **Line Items** section, acts as a summary of services as they are added to the Plan. Use the lower box to enter all authorized services.

Click **Procedure** field and type in the HCBS procedure code. Note as you type, the information appears in the **Line Items** field above.

Tab through the **Modifier** fields and enter modifiers if appropriate.

Plan of Care Maintenance Continued

TAB to **Requested Effective Date** field and type service start date in mm/dd/yyyy format. Note the down arrow next to this field. Clicking on the down arrow will bring up a calendar for the current month which allows the option of clicking on a date which will automatically fill the effective date field.

TAB to **End Date** field and repeat above procedure. MRDD Users will enter the last day of the beneficiary's birth month; SED Users will use a one year anniversary date; all other Waivers will use the end date of 12/31/2299.

HOW TO ENTER UNITS/DOLLARS

Users will enter **Units** when MMIS is set to allow a specific amount for one unit of service. Units will be used for all HCBS services **except** those noted below.

Dollars will be used when the amount allowed is calculated by a negotiated rate. Use **Dollars** when the procedure code is based on a dollar amount allowed on the POC, rather than units:

- MRDD-Home Modification
- MRDD-Vehicle Modification
- MRDD-Specialized Supplies, not otherwise specified
- MRDD-Specialized Medical Equipment
- PD-Personal Services
- PD-Assistive Technology
- HI-Personal Services
- HI-Assistive Technology

Both **Units** and **Dollars** should be used when amount is calculated by tier level:

- MRDD-Habilitation Residential
- MRDD-Day Habilitation
- MRDD Attendant Care

In this case enter the monthly unit total in the **Units** field; enter the unit price (tier level rate) in the **Dollars** field.

TAB to **Units.** When appropriate, enter the amount of units being requested for this procedure code for a one month time period using the above requirements.

TAB to **Dollars** and again, using the above requirements, enter dollars as appropriate.

Plan of Care Maintenance Continued

TAB to **Payment Method** field. If the User entered:

- **Units**, use the drop down arrow to choose **Pay System Calculated Price**;
- **Dollars**, use the drop down arrow to choose **Cap Amount**;
- **Units** and **Dollars**, use the drop down arrow to choose **Pay PA Unit Fee**.

TAB to **Servicing Provider** field and enter the nine-digit provider number for provider performing this line item procedure. Tab to the next box to enter the provider's alpha-location code in upper case.

To add additional services, highlight the last entry in the **Line Items** box, click the **ADD** button and the **Line Item** field will empty to allow the User to enter the next service.

If line items need to be removed for this Plan, highlight the line by placing the cursor on the line to be removed and click on the **Remove** button on the right.

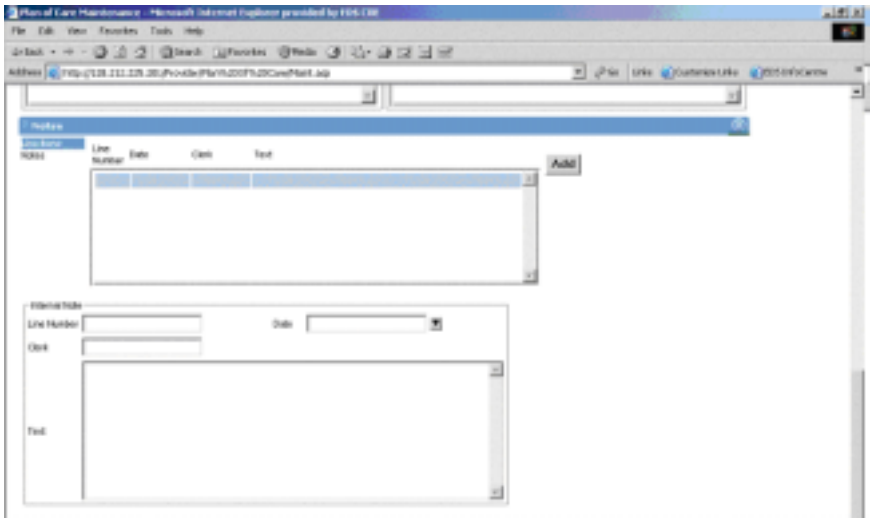
Field Descriptions:

Item	This field represents the alpha character itemizing the individual service on the Plan of Care. Each service has a unique line item character.
Procedure	This field represents the code identifying the procedure being requested.
Modifier	This field represents the modifier needed on some procedures. This field can be left blank if not relevant.
Requested Effective Date	This field represents the date that the case manager requests that the services start.
Requested End Date	This field represents the date that the case manager requests that the services end.
Requested Units	This field represents the number of units per calendar month for the service requested by the case manager.

Requested Dollars	If both dollars and units were entered, this field represents the tier rate for the beneficiary. If only dollars were entered, this field represents the dollar amount per calendar month for the service requested by the case manager. This amount may be prorated for a partial month.
Payment Method	
Authorized Effective Date	This field represents the approved date for the service to start.
Authorized End Date	This field represents the approved date for the service to end.
Authorized Units	This field represents the approved number of units per calendar month for the service.
Authorized Dollars	If both dollars and units were entered, this field represents the approved tier rate per calendar month for the service. If only dollars were entered, this field represents the approved dollar amount per calendar month for the service.
Servicing Provider	This field represents the provider number of the provider who is approved to perform the service.

Plan of Care Maintenance Notes

Notes



Every Plan of Care must be documented in the **Notes** field. Click on **Notes** on the left. This will bring up an **Internal Note Field.**

Indicate the date the note is being entered, and the User ID of the clerk entering the notes.

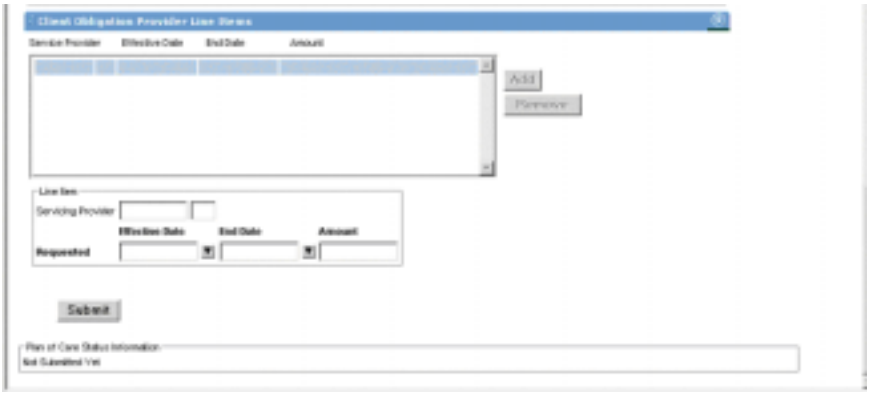
TAB to the Text Field and enter notes information. The Text Field is limited to 500 characters per note.

Click **Line Items** on left to go back to **Plan of Care Maintenance Screen.**

Field Descriptions:

Notes	This field represents communication text between case manager and SRS approval staff pertaining to specific line items.
Line Number	This field represents the line number of the line items; it is an alpha code and is automatically filled by the system once the Plan has been submitted to the approver.
Date	This field represents the date that the text was written.
Clerk	This field represents the ID of the clerk that entered the internal notes
Text	This field represents the content of the communication.

Client Obligation



Use the scroll bar on the right hand side of the window to move down to the **Client Obligation Provider Line Items** field. Client obligations will be assigned to specific providers using this area. If there is no client obligation for the beneficiary, this information can be left blank.

The upper box in the **Client Obligation** section, act as a summary of the information that is added in the lower box.

If beneficiary has a client obligation, begin by scrolling up to the **Total Client Obligation** field and highlight the Client Obligation line/month to be assigned. Make note of the amount.

Scroll down to the **Client Obligation Provider Line Items** field and click on the **Servicing Provider** field in the lower box. Enter the nine-digit provider number. **TAB** to the next field to enter the provider's alpha location code using upper case letters. Note information being entered will appear in the field above.

Type **Effective Date**, **End Date**, and Client Obligation **Amount** in the appropriate fields. If the beneficiary has different Client Obligations for different months, Users must always scroll up to the Total Client Obligation field and highlight the next Client Obligation line/month and then scroll back to the Client Obligation Provider Line Items in order to enter the next Client Obligation. The information that appears in the Provider Line Items box may appear or disappear, depending on which line is highlighted in the Total Client Obligation field.

NOTE: the **Effective Date** & **End Date** entered for the Client Obligation must be within the dates of that specific Plan of Care.

If a line has been entered incorrectly, it may be removed by using the **Remove** button on the right. Highlight the line to be removed and click on the **Remove** button.

At this point, carefully review the information on the Plan of Care. If information is correct, Users must click on the **Submit** button to save information. Do not repeatedly click on Submit, until you receive either a "Successfully Saved," or "Unsuccessfully Saved" message. In some cases, doing so has created extra POCs.

If an error has been made while entering the Plan of Care, Users will receive an "Unsuccessfully Saved" message. The error must be corrected before continuing. See Appendix C for Transaction Error List or call the HCBS Help Desk for more information.

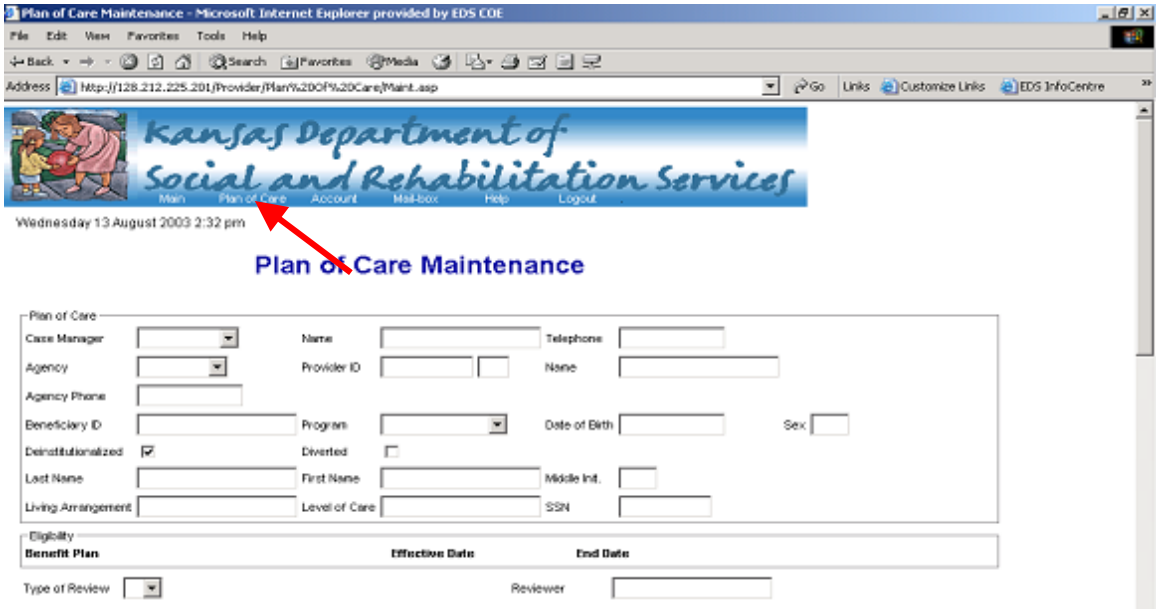
It is also recommended that once the Plan has been submitted, the screen should be refreshed before making any changes. This will help Users avoid error messages. Users may do that by going to the Kansas SRS banner at the top of the screen; move the cursor over *Plan of Care* and click on Inquiry. Using the search screen, enter the beneficiary's ID to pull up the existing POC.

Once the "Successfully Saved" message appears, the User may continue on to the next Plan of Care or log off of the system.

Field Descriptions:

Servicing Provider	This field represents the provider number of the provider who is responsible for collecting the client obligation.
Requested Effective Date	This field represents the date that the case manager requests that the services start.
Requested End Date	This field represents the date that the case manager requests that the services end.
Requested Amount	This field represents the dollar amount that the client is responsible for paying to the service provider each month within the requested dates.
Plan of Care Status Info	This field represents the current status of the Plan of Care.

Return to POC Search Screen

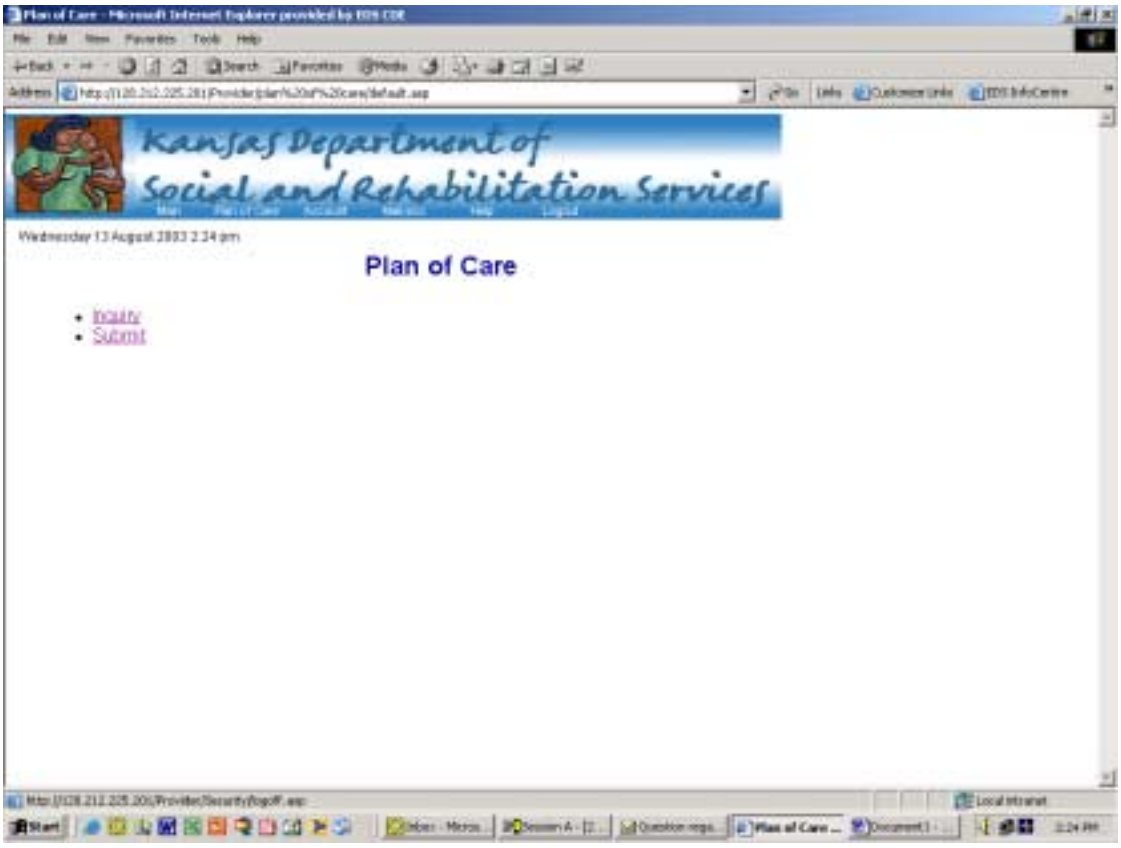


To return to the POC Search Screen, click on Plan of Care found in the banner at the top of the screen. Two options are given: Inquiry or Submit. Choose one.

Notes

Section Four: Changing an Existing POC

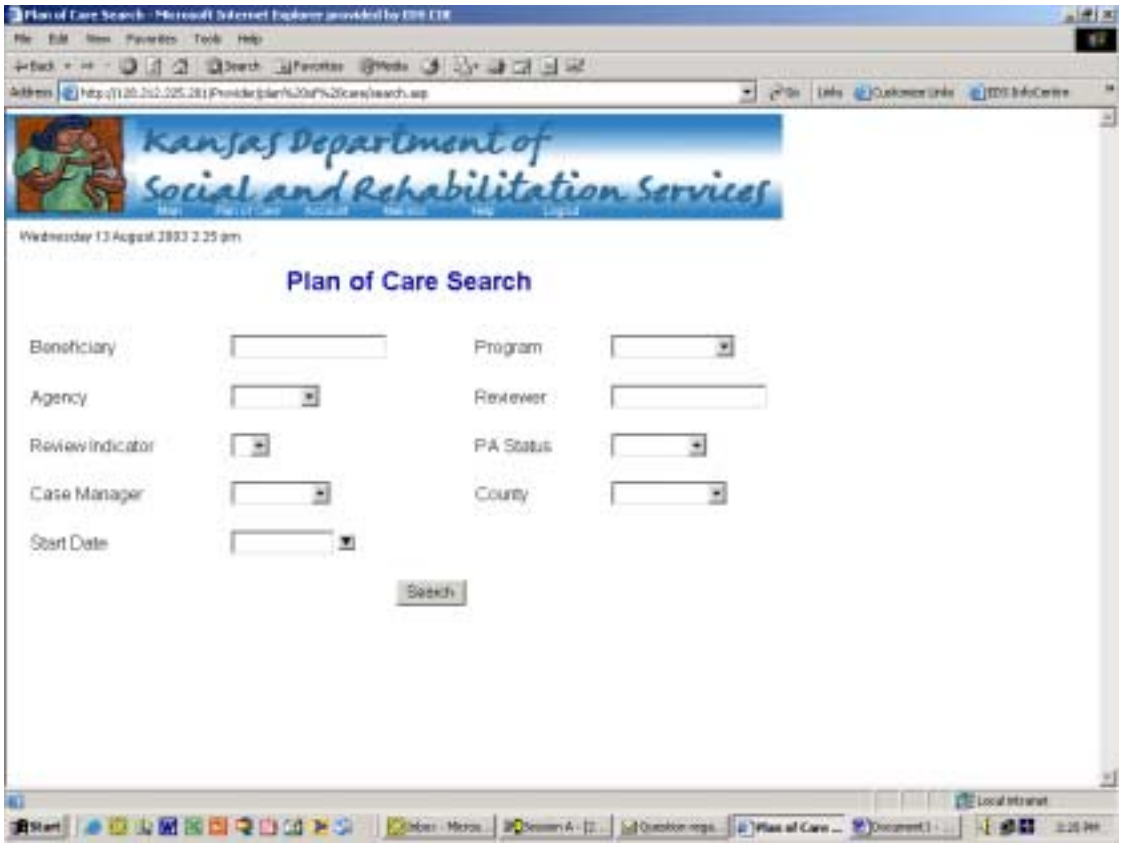
Plan of Care Inquiry



All changes and updates will be completed using the **Inquiry** option.

Click on **Inquiry**.

Plan of Care Search



Searching can be as broad or as narrow as desired. The more fields that are completed, the more specific the search results. However, at least one of the following must be used:

- Beneficiary (ID number)
- Beneficiary, Agency & Status
- Case Manager & Status
- Reviewer & Status

For example, to check a workload for a specific case manager for a specific program, fill the Case Manager and the PA Status fields and click on the **Search** button.

Another example would be to check all plans in Evaluation status for a specific agency, fill the Agency and PA Status field, and click on the **Search** button.

Users should frequently check for any Plans in Rejected status. These POC have been submitted to the Approver but were rejected for a specific reason. They require the User's attention and can be resubmitted to the Approver after responding to the problem.

Remember that only Plans of Care that are assigned to the User's agency will be available for viewing.

Field Descriptions:

Beneficiary This field represents the identification number for the beneficiary.

Program This is the assignment code that identifies the waiver program.

Agency This is the code that represents the responsible agency for this Plan of Care.

Reviewer This field represents the ID of the person assigned to review the Plan of Care.

Review Indicator This field represents the type of review:
I = Initial
R = Review
A = Annual.

PA Status

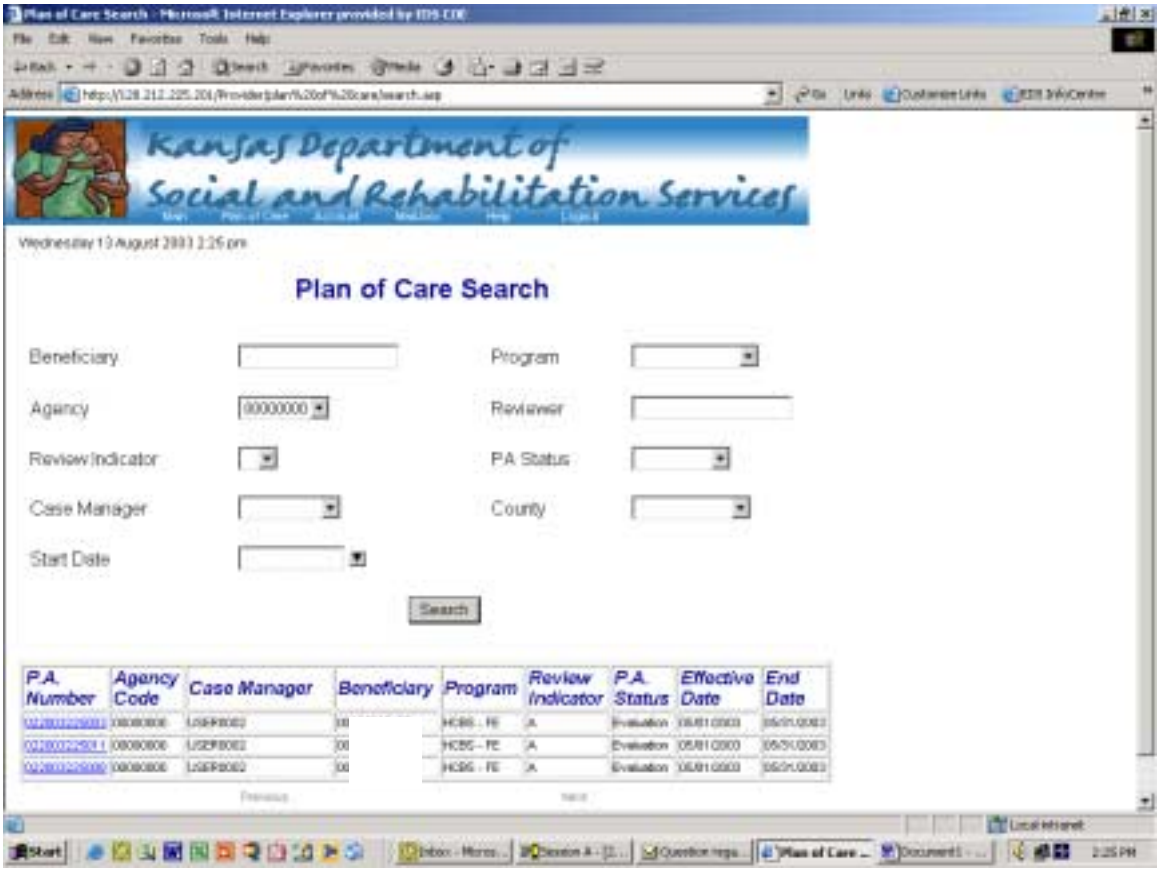
- **Approved** This is used when a Plan of Care has been approved for payment.
- **Cancelled** This may be used when a Plan of Care has been is in error. Often a new, corrected POC will be entered.
- **Evaluation** This Plan of Care is "pending," waiting for review by the Approver.
- **Modified** This is not used in the current Plan of Care system.
- **Rejected** This will be used when a Plan of Care has been sent back to the case manager for changes.

Case Manager This is the identification number for the case manager assigned to the Plan of Care.

County This field represents the two digit county code in which the beneficiary resides**.**

Start Date This field represents the approved start date of the Plan of Care.

Plan of Care Search Continued



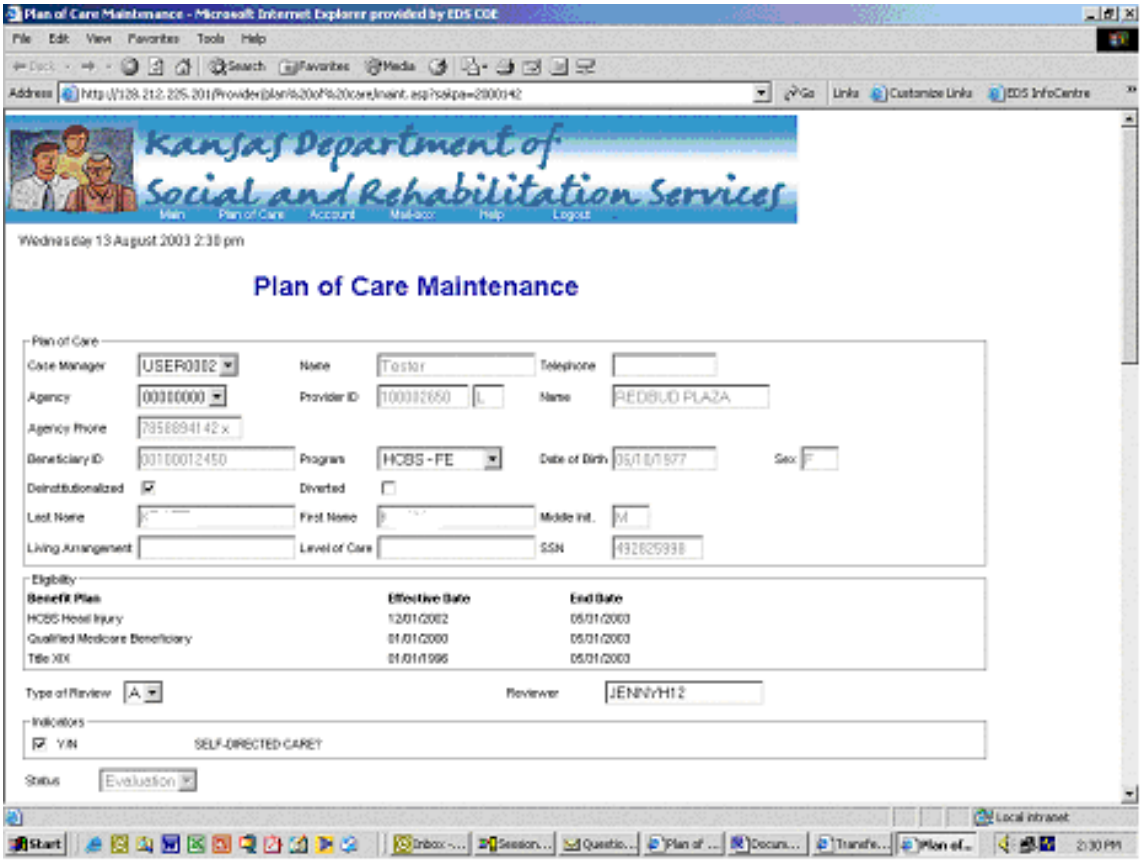
After clicking on the **Search** button, all plans meeting the search criteria will appear below the **Search** button. When **Previous** or **Next** appears in bright blue print at the bottom of the screen, Users may click on the word to move forward or backwards through the list.

Once the desired POC has been found, place cursor on the PA Number field and click once.

Field Descriptions:

P.A. Number	This field represents the number assigned to a Plan of Care after it has been submitted for approval.
Agency	This field represents the responsible agency for this Plan of Care.
Case Manager	This field represents the identification number for the case manager assigned to the Plan of Care.
Beneficiary	This field represents the identification number for the beneficiary.
Program	This field represents the assignment code that identifies the waiver program.
Review Indicator	This field represents the type of review
PA Status	This field represents the current status of the Plans of Care.
Effective Date	This field represents the approved date for the service to start.
End Date	This field represents the approved date for the service to end.

Plan of Care Maintenance Changes



The plan will appear. As of October 2003, all Plans of Care cover a time span, rather than one POC for one month. Plans will not 'roll over' to create a new Plan for the next month. Rather, one Plan will remain in effect for the entire time from the **Effective Date** through the **End Date**.

Review the current information. Any changes will be made on the **Plan of Care Maintenance** window by entering the Reviewer's code in the Reviewer box and scrolling down into the body of the Plan.

Field Descriptions:

Case Manager	This is the identification number for the case manager assigned to the Plan of Care.
Name	This field auto fills with the name of the case manager assigned to the Plan of Care.
Telephone	This field auto fills with the phone number for the case manager assigned to the Plan of Care.
Agency	This is the code that represents the responsible agency for this Plan of Care.
Provider ID	This field auto fills with the provider ID number corresponding with the responsible agency for this Plan of Care.
Name	This field auto fills with the name of the agency responsible for this Plan of Care.
Agency Phone	This field auto fills with the responsible agency's phone number.
Beneficiary ID	This field represents the identification number for the beneficiary.
Program	This is the assignment code that identifies the waiver program.
Date of Birth	This field auto fills with the beneficiary's date of birth listed on the SRS eligibility file.
Sex	This field auto fills with the beneficiary's sex code listed on the SRS eligibility file.
Deinstitutionalized	This field is checked for beneficiaries who have been in an institution at some point.
Diverted	This field is checked for beneficiaries who have **never** been institutionalized.
Last Name	This field auto fills with the beneficiary's last name from the SRS eligibility file.
First Name	This field auto fills with the beneficiary's first name from the SRS eligibility file.
Middle Init	This field auto fills with the beneficiary's middle initial from the SRS eligibility file.
Living Arrangement	This field auto fills with the Living Arrangement from the SRS eligibility file.
Level of Care	This field auto fills with the Level of Care Code from the SRS eligibility file.
SSN	This field auto fills with the beneficiary's Social Security Number from the SRS eligibility file.

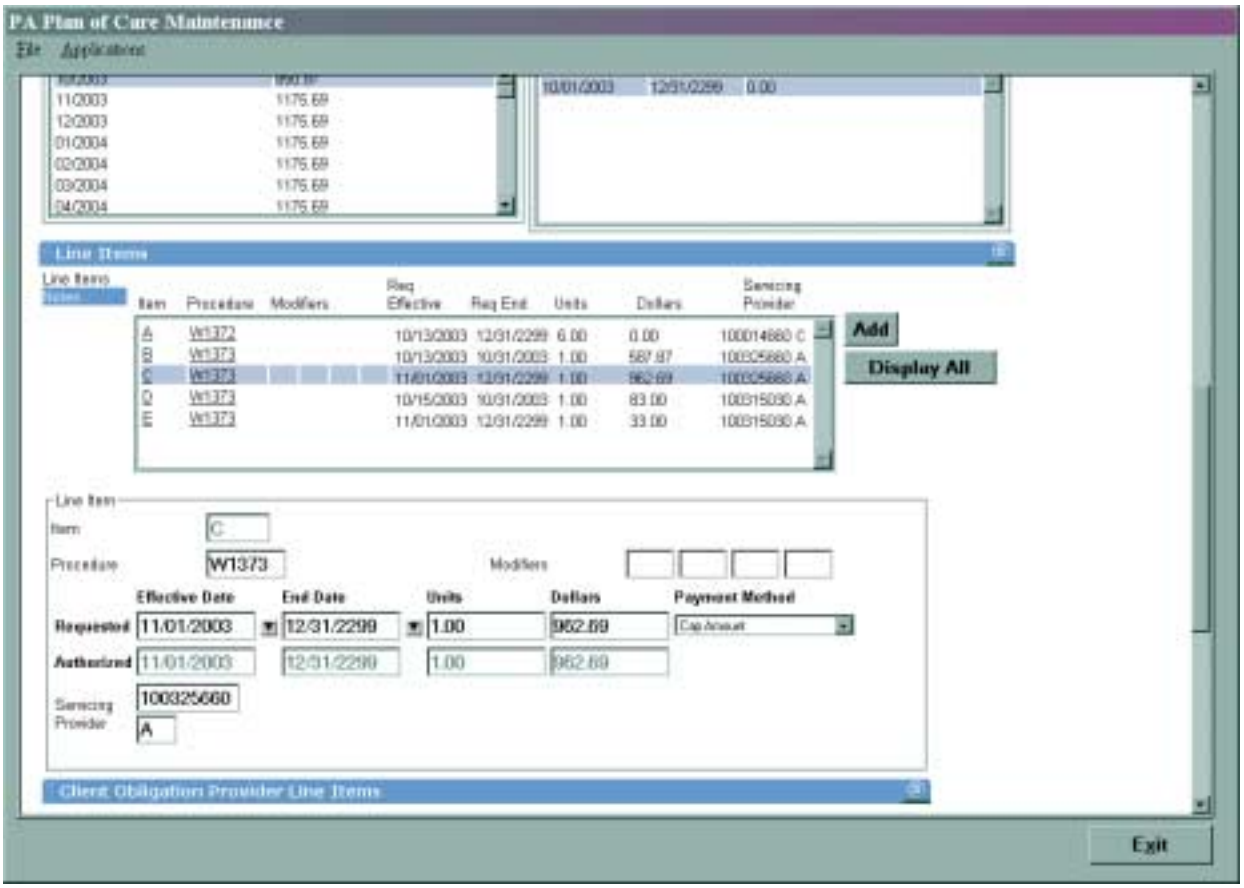
Eligibility:

Benefit Plan	Reference Appendix D
Effective Date	This field represents the start date of the benefit plan.
End Date	This field represents the end date of the benefit plan.
Type of Review	This field represents the type of review **"I"** is initial and is used for the initial Plan of Care for a beneficiary. ("I" will only be used once per beneficiary.) **"A"** is annual and is to used at the regularly scheduled annual re-assessment of the beneficiary. **"R"** is for revised and is to used to make a revision at any time other than the initial or annual Plan of Care.
Reviewer	This field represents the ID of the person that is assigned to review the Plan of Care.

Plan of Care Maintenance Changes

Line Items

Units and/or dollars may be increased at any time; Users should decrease units and dollars **only** after checking with the HCBS Help Desk (785-274-5961) or their Approver, to determine the change will not effect any paid claims. A future enhancement will allow Users to view used and remaining dollars/units at this window.

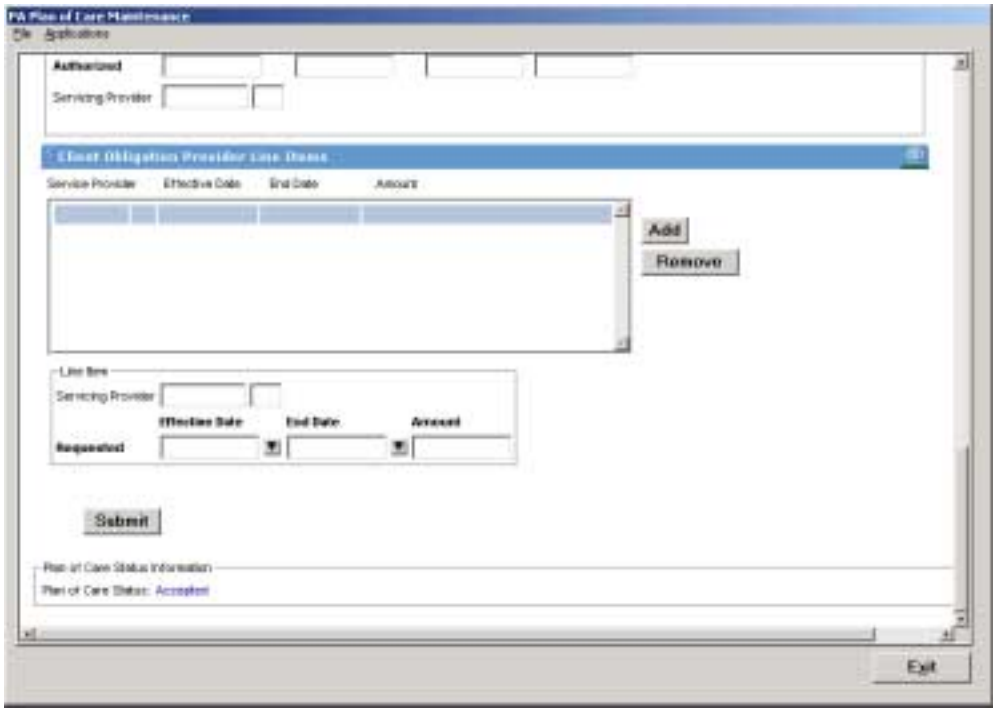


In the above example, the User needed to change the total dollars allowed for Line items B & D. An end date of 10/31/03 was entered and then line items C & E were added. Line item A required no changes.

Plan of Care Maintenance Changes Continued

When adding line items above, the User highlighted the line item B and clicked the **Add** button to the right. The box below emptied, allowing the User to enter the new line item. Line item D was then highlighted, the **Add** button clicked and the next new line item was added. It is not necessary to click **Add** after the item has been added, only before.

If a line has been entered incorrectly, it may be deleted only if there are no paid claims. Users will highlight the line item to be deleted and use the **Remove** button to the right of the field. A warning will appear to caution users to make sure they are not deleting a line that is associated with a paid claim. Using this option will then allow the case manager to enter the line correctly.



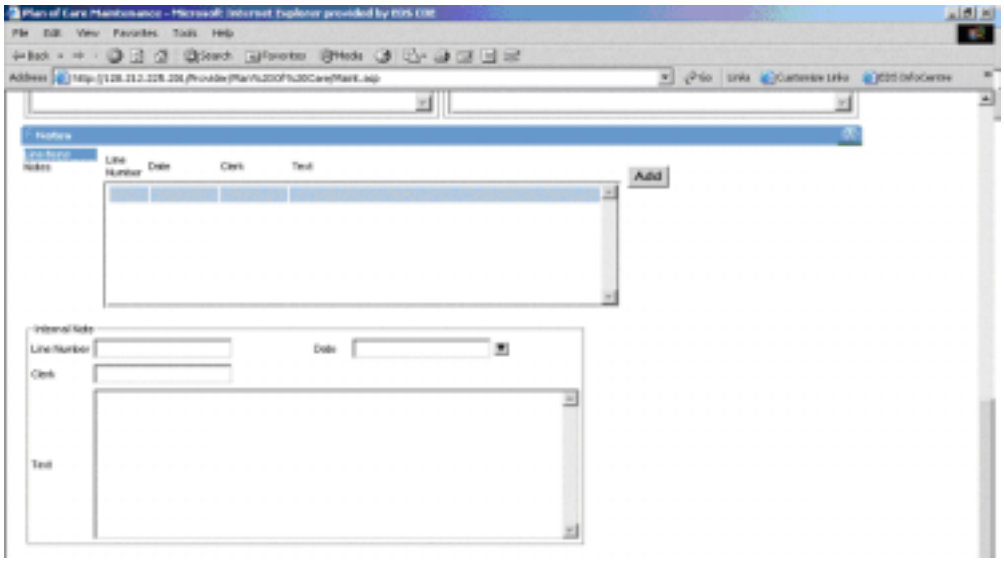
When changing the Plan or adding new line items always click on the **Submit** button to save changes. This automatically updates the plan to be approved. Do not repeatedly click on Submit, until you receive either a "Successfully Saved," or "Unsuccessfully Saved" message. In some cases, doing so has created extra POCs.

If an error has been made while entering the Plan of Care, Users will receive an "Unsuccessfully Saved" message. The error must be corrected before continuing. See Appendix C for Transaction Error List or call the HCBS Help Desk for more information.

Once the POC has been submitted, the status will default to EVALUATION.

It is also recommended that once the Plan has been submitted, the screen should be refreshed before making any changes. This will help Users avoid error messages. Users may do that by going to the Kansas SRS banner at the top of the screen; move the cursor over *Plan of Care* and click on Inquiry. Using the search screen, enter the beneficiary's ID to pull up the existing POC.

Notes



All changes to the Plan should be documented in the notes section. Highlight the word **Notes**; any internal notes will appear. Click on **Add**. Enter the date, the User's ID and add test. Click on **Line Items** when the note is complete.

Changing Client Obligation

To change the client obligation, begin by scrolling up to the Total Client Obligation field and highlight the Client Obligation line/month to be assigned.

Scroll down to the Client Obligation Provider Line Items field and click on the **Servicing Provider** field in the lower box. Enter the nine-digit provider number. Tab to the next field to enter the provider's alpha location code using upper case letters. Note information being entered will appear in the field above.

Enter the **Effective Date**, **End Date**, and Client Obligation **Amount** in the appropriate fields. If the beneficiary has different Client Obligations for different months, Users must scroll up to the Total Client Obligation box and highlight the next Client Obligation line/month and then scroll back to the Client Obligation Provider Line Items in order to enter the next Client Obligation.

If the Client Obligation has been entered in error, highlight the incorrect line and click on the **Remove** button on the right.

When entering the end date on the Plan, use the same end dates as used for the **Line Items**.

If the client obligation has changed to $0.00, enter an end date for the previous line and nothing further needs to be done.

Always **Submit** after removing a line.

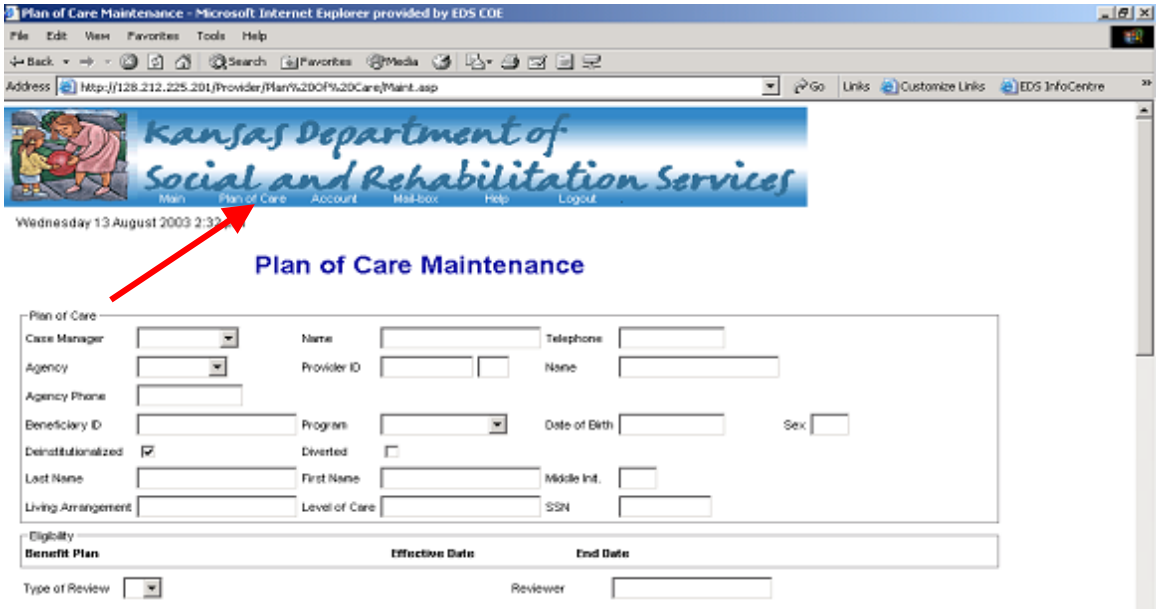
After submitting, always refresh screen before making additional changes.

.

Field Descriptions:

Servicing Provider	This field represents the provider number of the provider who is responsible for collecting the client obligation.
Requested Effective Date	This field represents the date that the case manager requests that the services start.
Requested End Date	This field represents the date that the case manager requests that the services end.
Requested Amount	This field represents the dollar amount that the client is responsible for paying to the service provider each month within the requested dates.
Plan of Care Status Info	This field represents the current status of the Plan of Care.

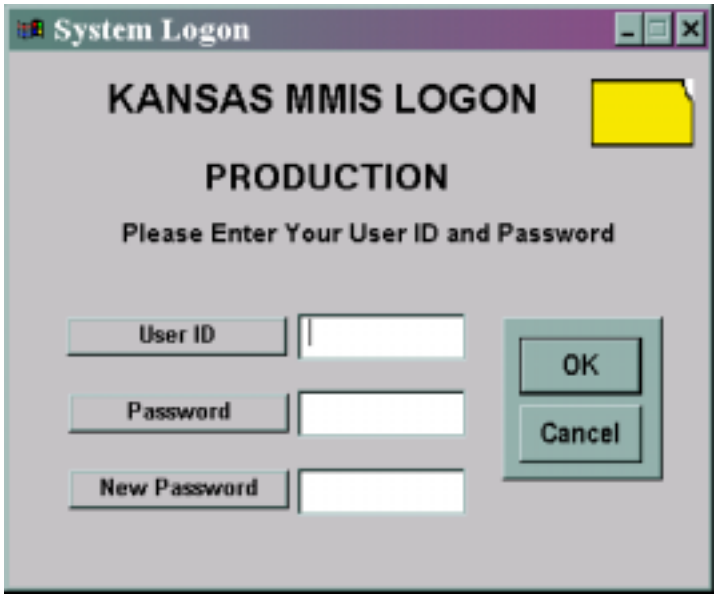
Return to POC Search Screen



To return to the POC Search Screen, move the curser over the *Plan of Care* found in the banner at the top of the screen. Two options are given: Inquiry or Submit. Choose one.

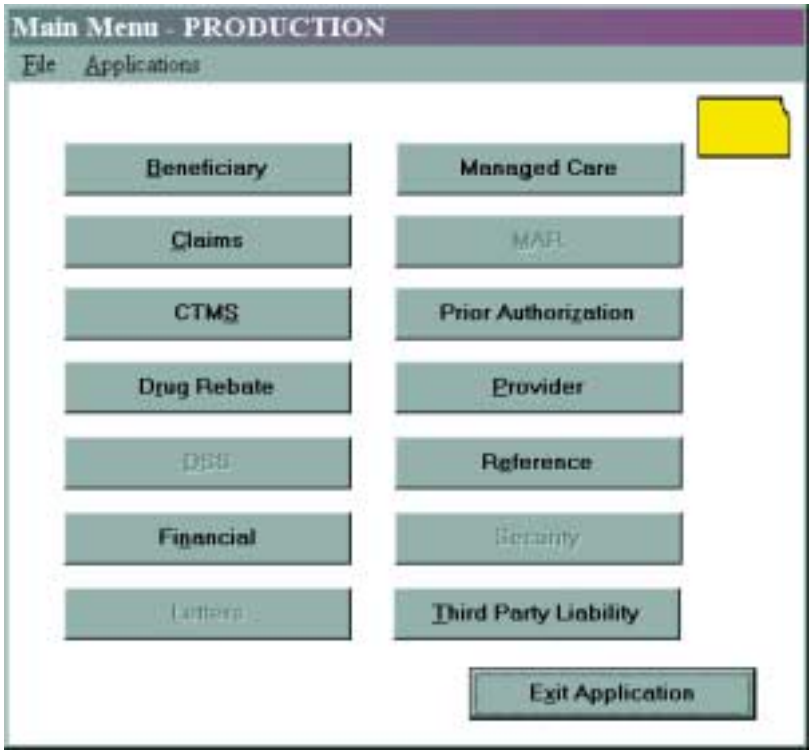
Section Five: Approving an Existing Plan of Care

Kansas MMIS - Production



Approvers will use *Kansas MMIS Production* to Approve Plans of Care. Contact your IT staff if the *KSMMIS Prod* icon has not been added to your desktop. The SRS security staff will assign a User ID and initial password to all Approvers.

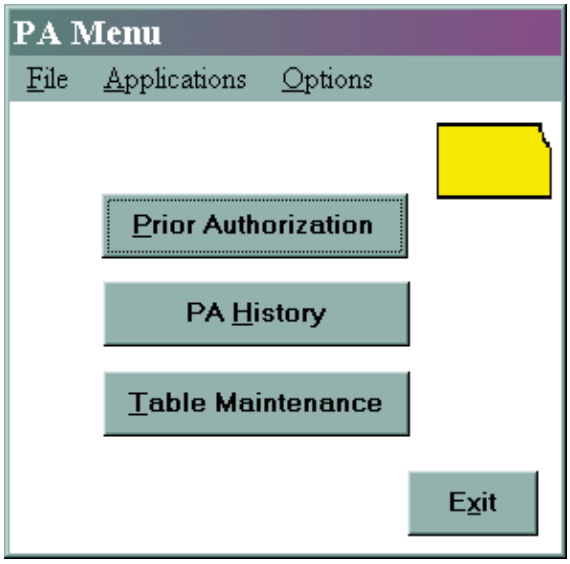
Main Menu – Production



The Prior Authorization option will allow Approvers to view all Prior Authorization within the interChange Medicaid Management Information System.

Click on the **Prior Authorization** button.

PA Menu

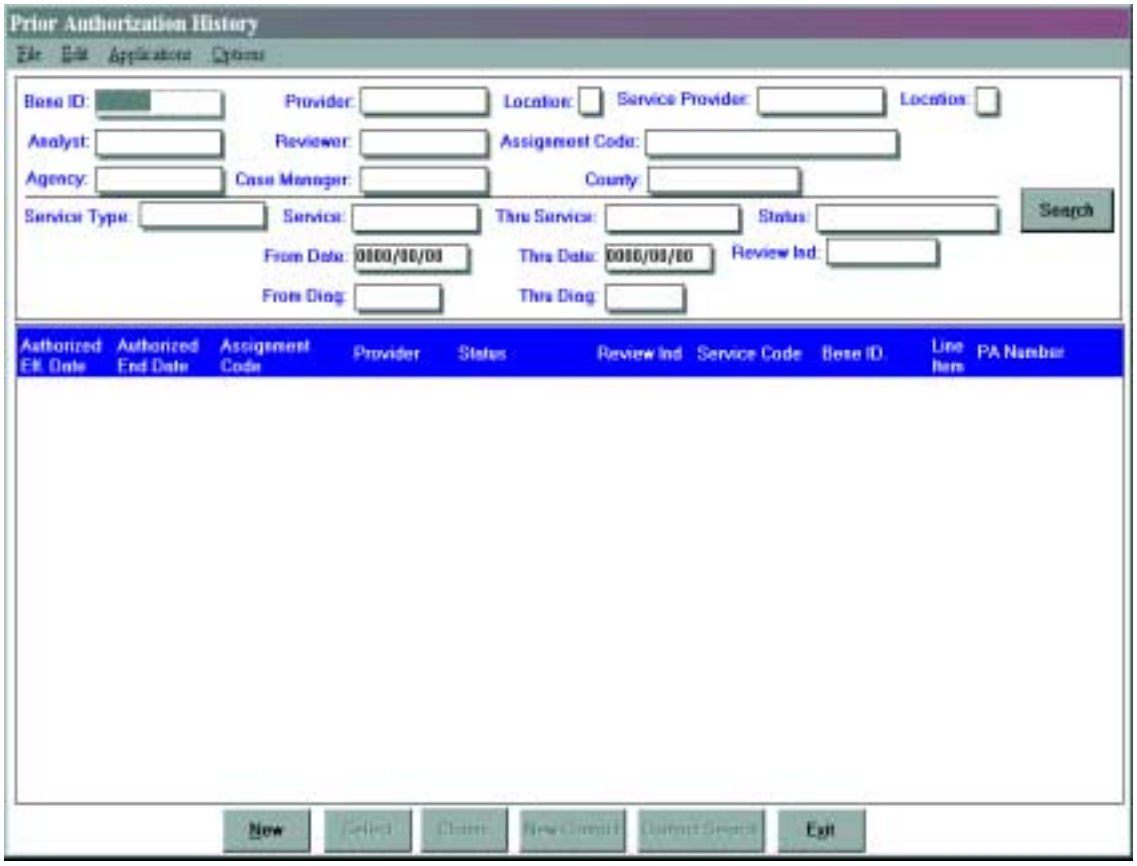


The **Prior Authorization** and **Table Maintenance** buttons are for use by the fiscal agent.

Approvers will use the **PA History** option to view Plans of Care.

All screens will stack upon one another; screens cannot be minimized.

Prior Authorization History



Once the Prior History window appears, a variety of options may be used in searching for Plans of Care.

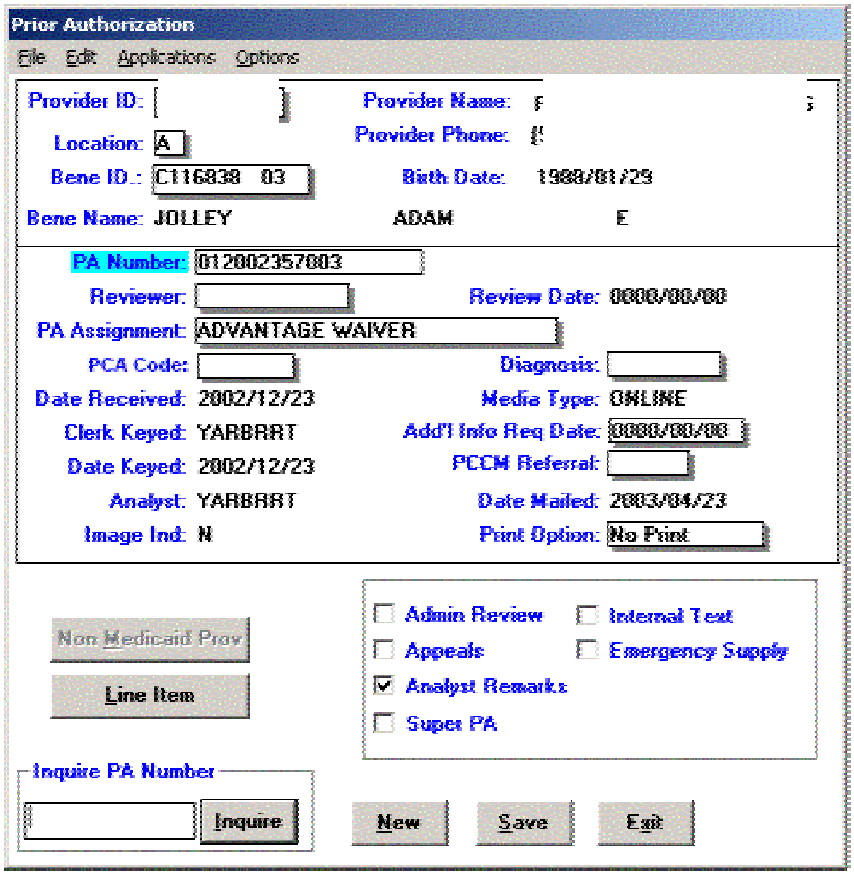
To find a specific consumer, Approvers will enter the Bene ID, tab to the Assignment Code and use the drop down box to find the appropriate waiver. Click on the **Search** button.

Approvers will check their workload by entering their User ID in the drop down box in the **Reviewer** field and then tabbing to the **Status** field and choosing **Evaluation.** Click on the **Search** button. Approvers will view all Plans of Care that have been sent to them for approval.

Approvers can also review all Plans for a specific agency or for a case manager, by entering the Agency or case managers number in the appropriate field and using the Status field. Click on the **Search** button.

Once a specific Plan of Care has been identified, Approvers may either double click on that line item or after highlighting the line, click on the **Select** button at the bottom of the screen.

Prior Authorization

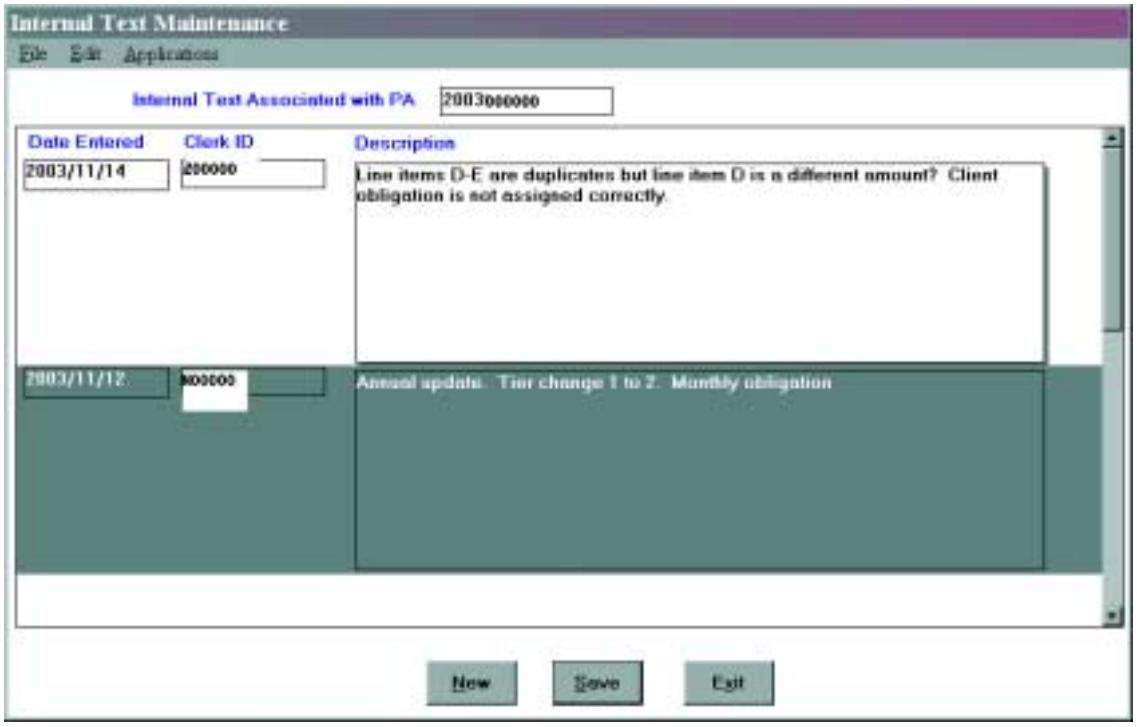


The Prior Authorization window identifies basic information about the Plan of Care. The Case Management agency is identified, along with the consumer's name and Bene ID. The PA number, the waiver, the Clerk ID and the date the POC was entered can also be found on this screen.

A check mark in the **Internal Text** field indicates there are notes attached to this Plan of Care. (The other options in this box are for use by the fiscal agent.) As Users enter or make changes to the Plans of Care on the web, they are required to enter documentation in the **Notes** field of the Plan. The Approver can view these notes by double clicking on the words **Internal Text.**

Prior Authorization

Internal Text

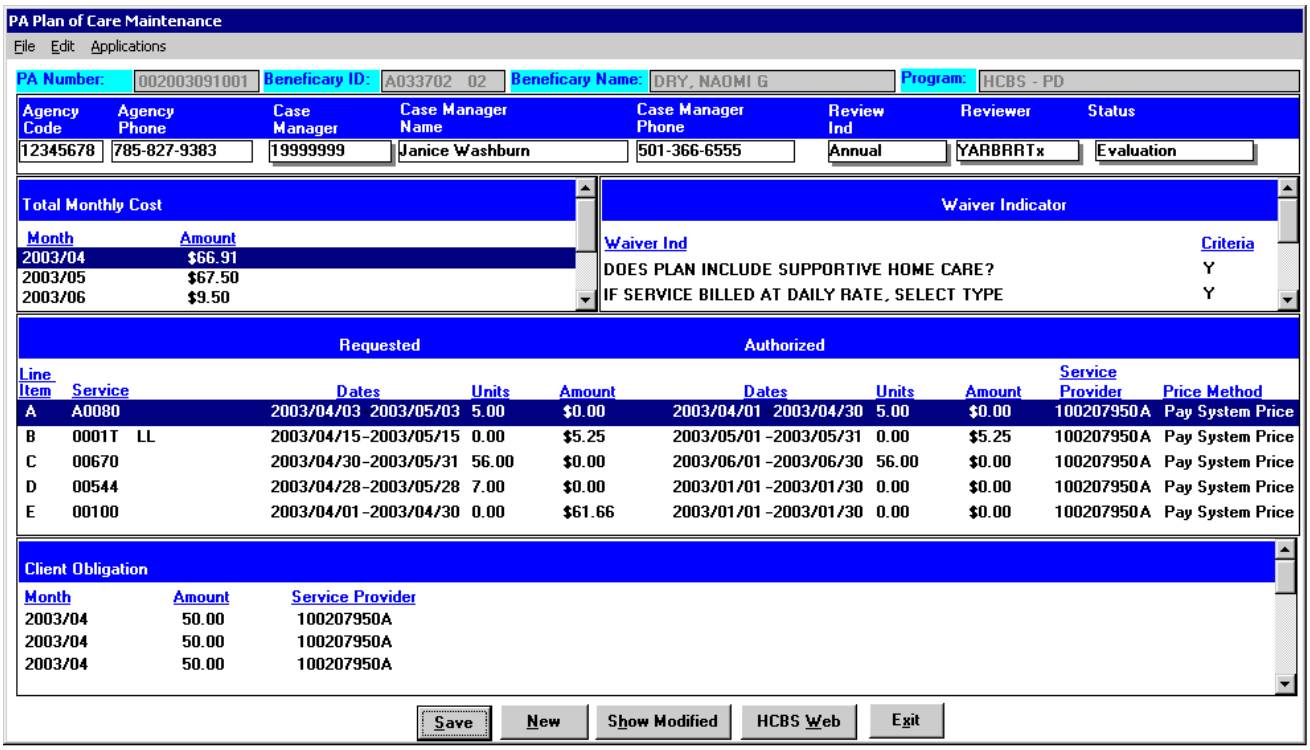


This information will aid Approvers in determining the appropriateness of the Plan and will provide calculations to help explain the total cost. Notes will appear in chronological order with the most recent note first. Use the scroll bar on the right side of the window to view all notes related to this Plan of Care.

Approvers must also note their actions at this window. Click **New** and add the date, the Approver's User ID and any comments about this Plan of Care. Click **Save** and the **Exit** to return to the Prior Authorization window.

Once at the Prior Authorization Window click on **Line Item** (see example of this window on page 5.5.) to view the Plan of Care.

PA Plan of Care Maintenance



Approvers may view the Plan of Care in its entirety from this window. The window includes:

- the PA Number,
- Bene ID & Bene Name,
- Program (Waiver),
- the Agency Code & Agency Phone,
- Case Manager/Data Entry Clerk's ID, Name and Phone,
- Review Indicator,
- Reviewer's name,
- Status of the Plan of Care,
- Total Monthly Cost,
- Waiver Indicator Questions,
- the services to be authorized (Line Items) and
- Assigned Client Obligation.

PA Plan of Care Maintenance continued

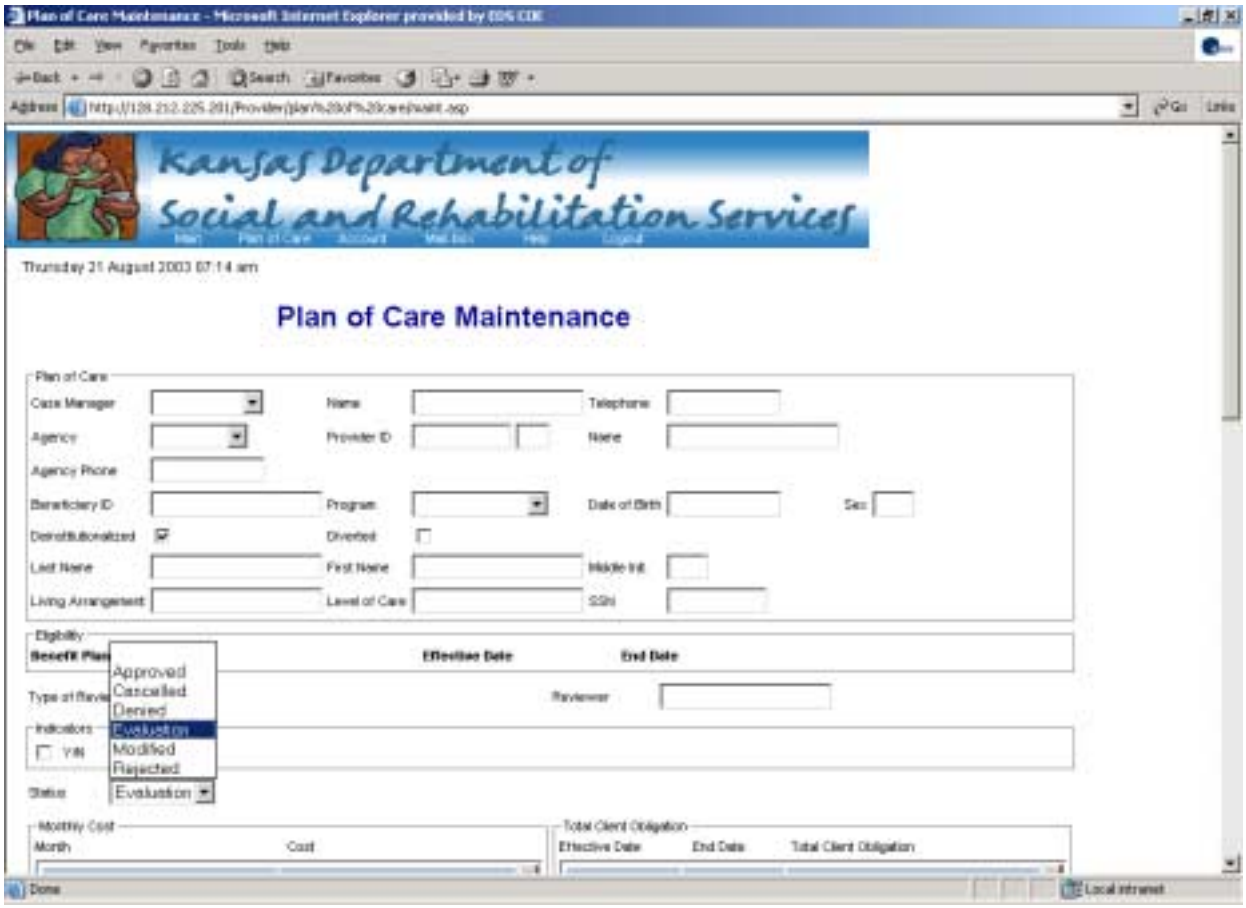
Note that the Total Monthly Cost, the Waiver Indicator questions and the Client Obligation fields have scroll bars on the right hand side when additional information is available.

Highlight the month to be viewed in the Total Monthly Cost box. All line items associated with that month will appear in the Line Item box. Line Items can be identified by the procedure code and are divided in sections as Requested and Authorized.

Approvers will use the drop down options in the Status field to approve, reject or cancel Plans of Care. Only use the cancel option when the whole Plan is invalid. Plans of Care cannot be deleted. Other options in the drop down box are for use by the fiscal agent and not applicable to HCBS Plans of Care.

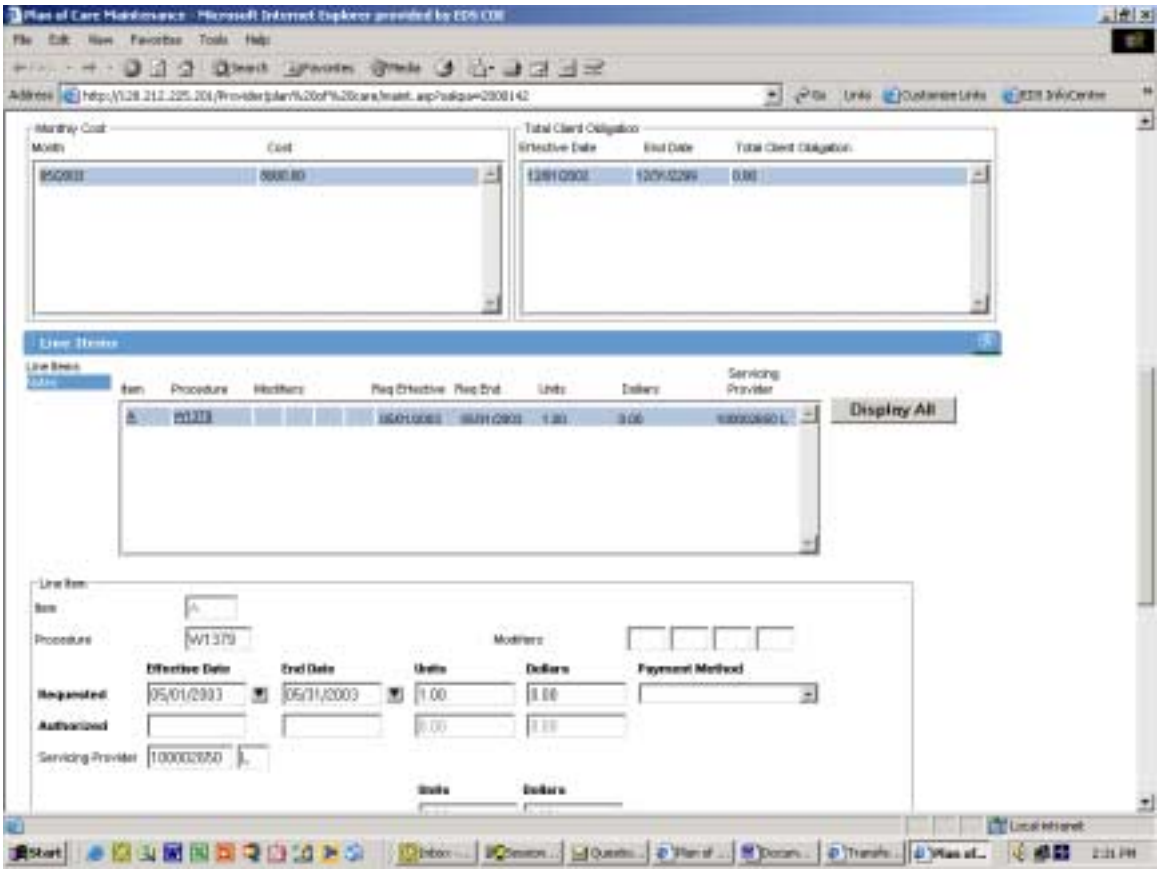
To make a change in the Plan, use the **HCBS Web** button at the bottom of the screen. However, if the Approver is making a change, the Status on the PA Plan of Care Maintenance screen must be **Evaluation** BEFORE making the change on the HCBS Web. This seems to cause fewer errors to occur.

Plan of Care Maintenance - Web



This is the screen the Case Manager used when entering the POC.

Plan of Care Maintenance - Web Continued

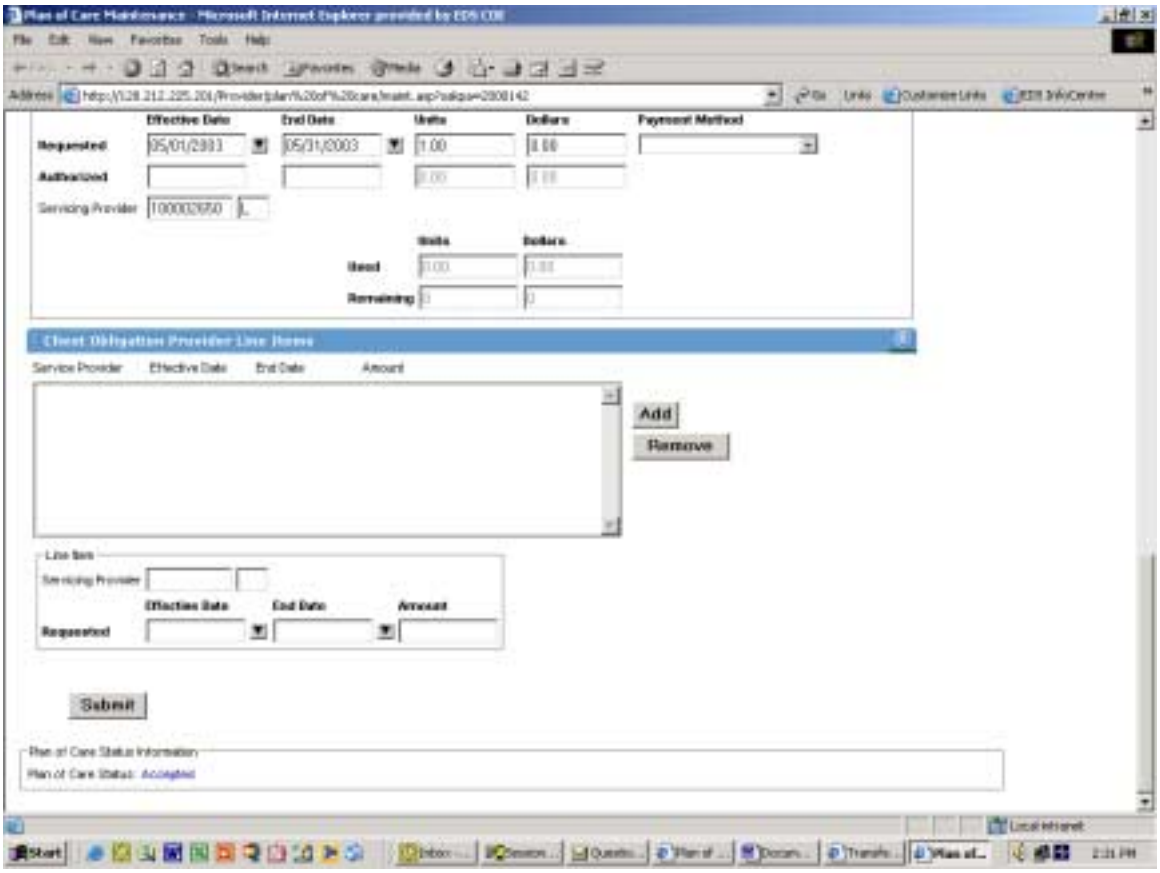


Line Items may be changed here.

Make any changes as appropriate. Please refer to *Section 4: Changing an Existing Plan of Care* of this manual for specific instructions in making changes.

Continue to scroll down through the Plan of Care.

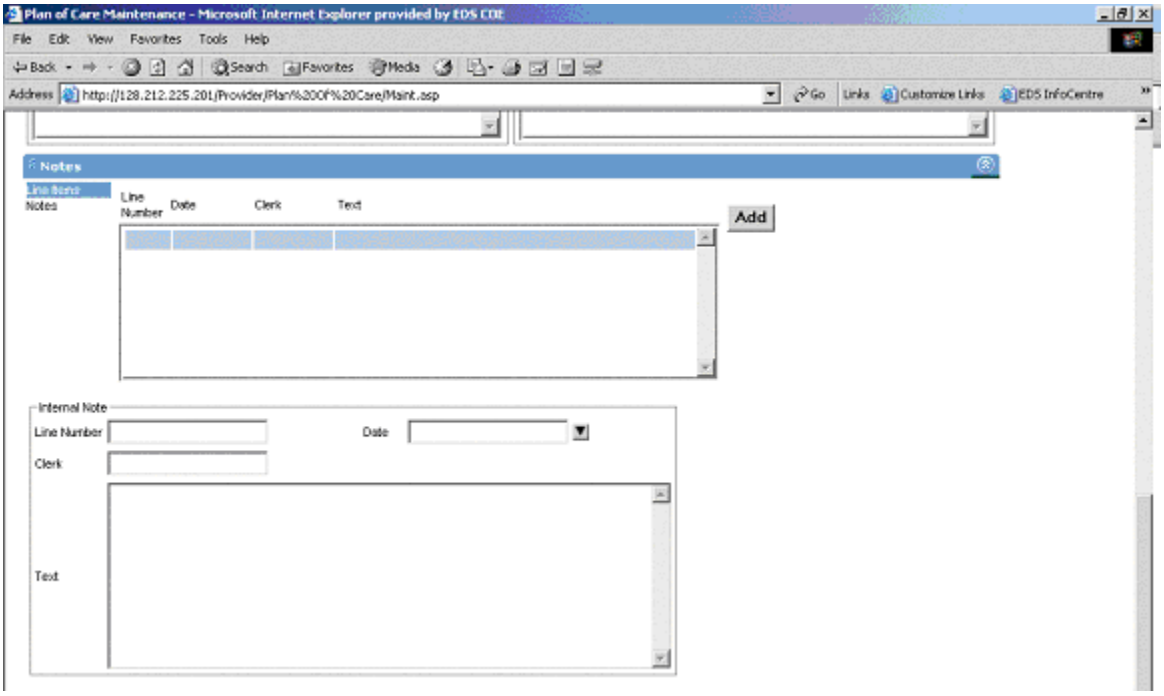
Plan of Care Maintenance Approval Continued



Client Obligation may be changed here.

Make any changes as appropriate. Please refer to *Section 4: Changing an Existing Plan of Care* of this manual for specific instructions in making changes.

Plan of Care Maintenance Notes



Approvers may make comments to the Plan when accessing it from the website as well as from the Prior Authorization window in Production. To add notes and comments, click on **Notes** on the left. This will bring up the Internal Note Field. Notes appear in chronological order with the most current note at the bottom.

Highlight the last entry in the **Notes** field. Click **Add**.

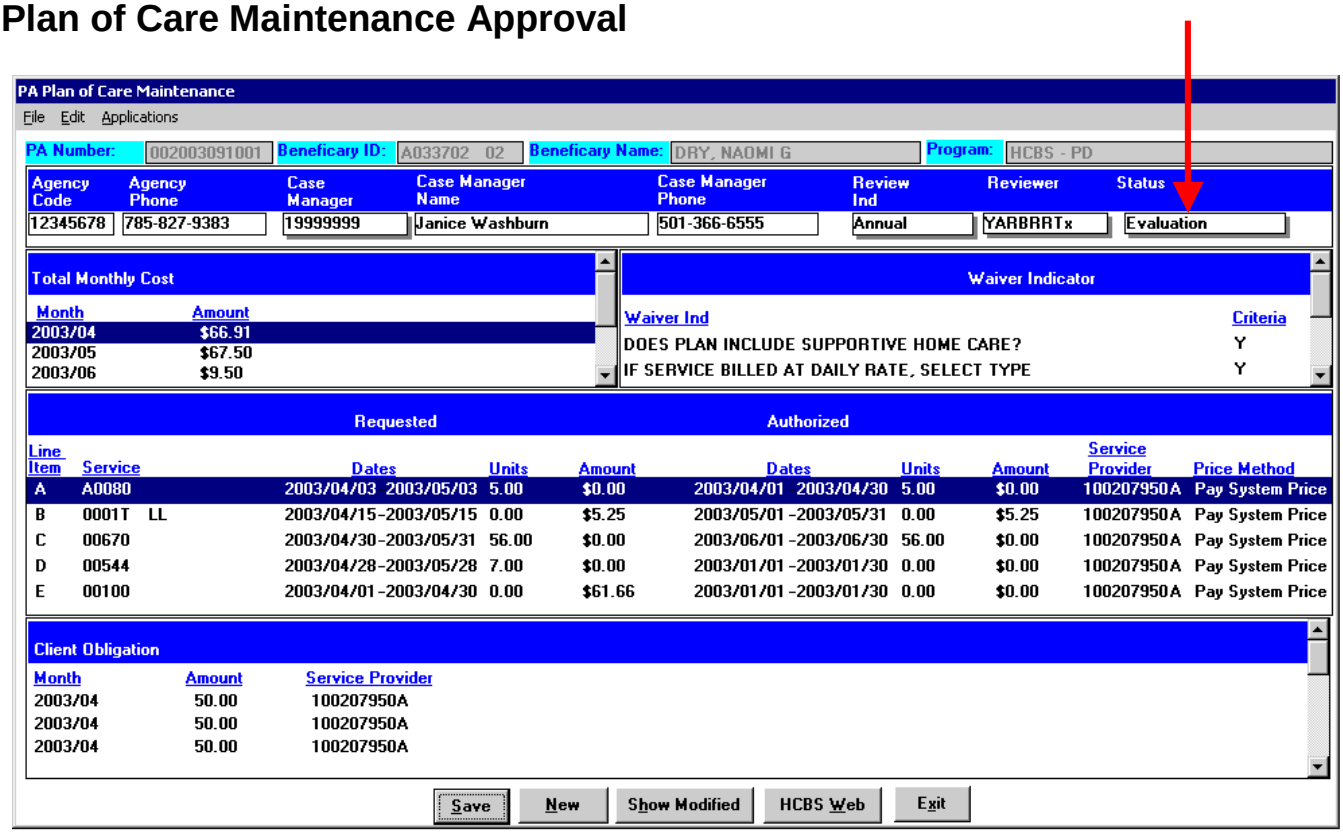
The **Internal Note** field will empty of any previous information and the Approver may then indicate the line item the note is specific to, the date the note is being entered, and the ID of the approver entering the notes.

Tab to the Text Field and enter notes information. The Text Field is limited to 500 characters per note.

Click **Line Items** on left to go back to Plan of Care Maintenance Screen.

Always select the **Submit** button before leaving the Plan of Care. This will ensure that the information that has been added/changed has been updated.

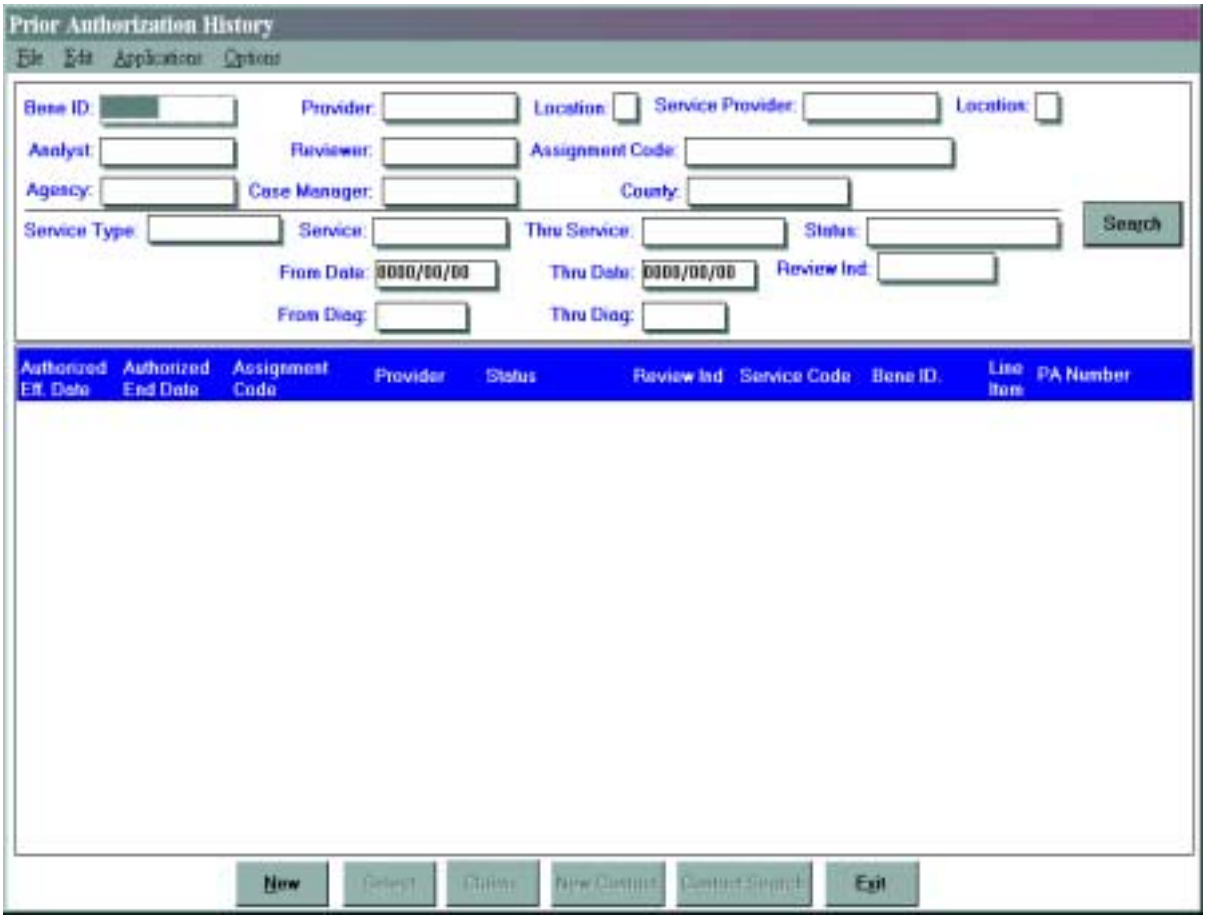
Plan of Care Maintenance Approval



Return to the POC Maintenance window to change the status of the POC. Always refresh the window to insure the changes appear. To refresh the window, Users may click on the **EXIT** button at the bottom of the screen to close the POC Maintenance window. Once at the Prior Authorization window click on the **Line Item** button. This will refresh the POC Maintenance window so that any changes are included. Use the Status drop down box to make this change.

Always click **Save** before closing the window.

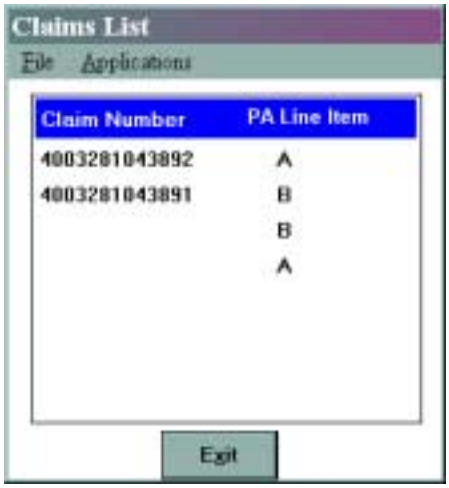
Viewing Paid Claims



As part of the approval process, Approvers will occasionally need to review paid claims. These can be viewed by returning to the Prior Authorization History screen.

Highlight the Plan to be reviewed and click on the **Claims** button at the bottom of the screen

Claims List



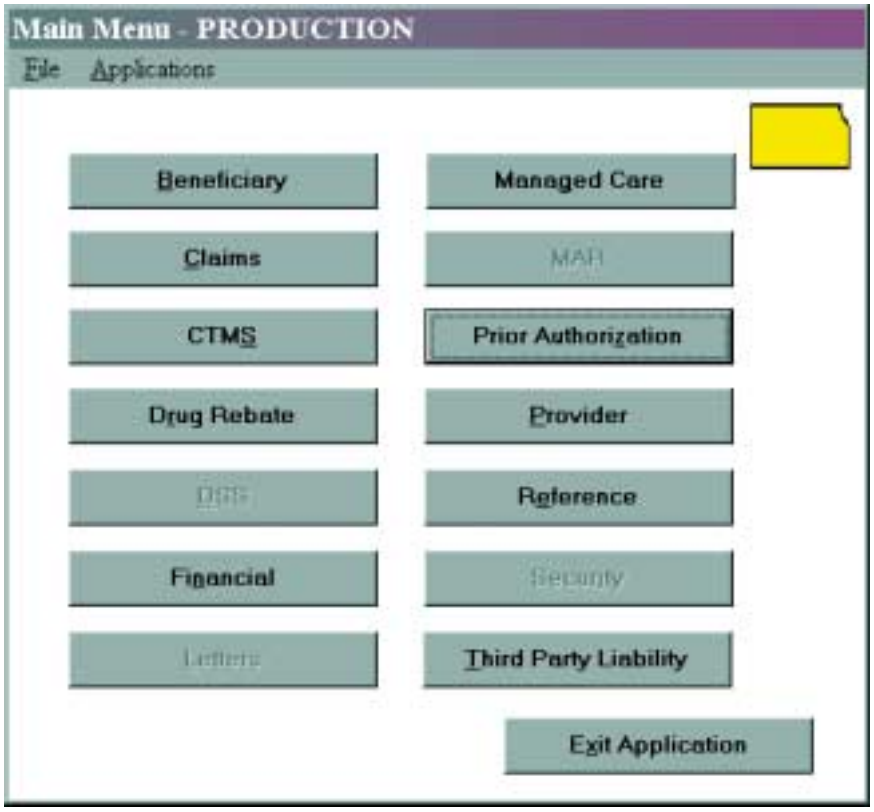
A window similar to the one above will appear. All claims associated with the Plan of Care will appear here with the Internal Control Number (ICN) and the Line Item from the POC. If a scroll bar appears on the right hand side of the window, scroll down to view additional entries. Double click on the Claim number to view the claim.

Please refer to the iCMMIS training manual for assistance in reading claims.

Use the **Exit** button to remove this window and return to the Prior Authorization window.

Section Six: Logoff

Use the **Exit** buttons at the bottom of each screen to exit the individual screens.



Clicking on the **EXIT Application** button on the Main Menu will log Approvers out of Kansas MMIS – Production.

Appendix A: Kansas County Codes

AL	Allen	GL	Greeley	OB	Osborne
AN	Anderson	GW	Greenwood	OT	Ottawa
AT	Atchison	HM	Hamilton	PN	Pawnee
BA	Barber	HP	Harper	PL	Phillips
BT	Barton	HV	Harvey	PT	Pottawatomie
BB	Bourbon	HS	Haskell	PR	Pratt
BR	Brown	HG	Hodgeman	RA	Rawlins
BU	Butler	JA	Jackson	RN	Reno
CS	Chase	JF	Jefferson	RP	Republic
CQ	Chautauqua	JW	Jewell	RC	Rice
CK	Cherokee	JO	Johnson	RI	Riley
CN	Cheyenne	KE	Kearney	RO	Rooks
CA	Clark	KM	Kingman	RH	Rush
CY	Clay	KW	Kiowa	RS	Russell
CD	Cloud	LB	Labette	SA	Saline
CF	Coffey	LE	Lane	SC	Scott
CM	Comanche	LV	Leavenworth	SG	Sedgwick
CL	Cowley	LC	Lincoln	SW	Seward
CR	Crawford	LN	Linn	SN	Shawnee
DC	Decatur	LG	Logan	SD	Sheridan
DK	Dickinson	LY	Lyon	SH	Sherman
DP	Doniphan	MN	Marion	SM	Smith
DG	Douglas	MS	Marshall	SF	Stafford
ED	Edwards	MP	McPherson	ST	Stanton
EK	Elk	ME	Meade	SV	Stevens
EL	Ellis	MI	Miami	SU	Sumner
EW	Ellsworth	MC	Mitchell	TH	Thomas
FI	Finney	MG	Montgomery	TR	Trego
FO	Ford	MR	Morris	WB	Wabaunsee
FR	Franklin	MT	Morton	WA	Wallace
GE	Geary	NM	Nemaha	WS	Washington
GO	Gove	NO	Neosho	WH	Wichita
GH	Graham	NS	Ness	WL	Wilson
GT	Grant	NT	Norton	WO	Woodson
GY	Gray	OS	Osage	WY	Wyandotte

Appendix B: Benefit Plans

- Aids Drug Assistance Program – Full Benefits
- Aids Drug Assistance Program – Tracking Only
- Expanded LMB – Stand Alone
- Foster Care Adoption
- Foster Care
- Foster Care Severely Emotionally Disturbed
- Family Preservation
- HCBS Developmentally Disabled
- HCBS Frail Elderly
- HCBS Head Injury
- HCBS Physically Disabled
- HCBS Severely Emotionally Disturbed
- HCBS Technology Assisted
- HealthConnect
- Hospice
- HealthWave 19 Dental
- HealthWave 19 Medical
- HealthWave 19 Mental Health
- HealthWave 21 Dental
- HealthWave 21 Medical
- HealthWave 21 Mental Health
- Punitive Lock-In
- Low-Income Medicare Beneficiary – Dual
- MediKan
- Medically Needy
- Program of All-Inclusive Care for the Elderly
- Qualified Medicare Beneficiary
- Qualified Disabled Working Individual – Stand Alone
- Sixth Omnibus Bill Reconciliation Act
- Tuberculosis
- Title XIX
- Title XXI (MCO) or Title XXI

Appendix C: Error Codes

Transaction Error List

Error Range

1-999 General errors that prohibit the application from running.

1000-1999 Data edit/validation errors. The data may be changed and re-submitted.

2000-2999 Data retrieval errors. The data found in the database doesn't fit the defined data model. The database must be corrected to get past this error.

4000-4999 Prior Authorization's data edit/validation errors. These errors are returned by the validation routine for prior authorizations. The data may be changed and re-submitted.

8000-8999 Internal configuration errors. Report these errors to EDS.

9000-9999 Database errors. Report these errorsto EDS

Error Code	Attribute	Message	User Action
1	db_connect	"Unable to connect to database."	Additional error messages may provide more information. Report this and all other messages to the system administrator.
2	db_connect	"DB user id not set."	Report this to the system administrator.
1001	Fname	"Invalid code specified."	Change the value of <fname> and re-submit.
1002	Fname	"Invalid date."	Change the value of <fname> and re-submit.
1003	fname	"Too many characters in value."	Change the value of <fname> and re-submit.
1004	init_select_fields	"No search criteria specified."	Change the value of <fname> and re-submit.
1010	PatientLiab	"Field value is missing."	Change the value of patientLiab and re-submit.
1011	Recipient	"Missing recipient."	Add a recipient and re-submit.
1012	Provider	"Missing provider."	Add a provider and re-submit.
1013	PatientLiab	"Unknown patient liability."	Change the value of patientLiab and re-submit.
1014	PatientLiab	"Dates out of range."	The dates specified for the obligation are out of the range of the dates of patientLiab. Change values for patientLiab, dateEffective, or dateEnd and re-submit.
1015	DateEnd	"Missing or invalid date."	Change the value of obligation dateEnd and re-submit.

1016	DateEnd	“Invalid date range.”	The obligation ending date is earlier than the effective date. Change the date range and re-submit.
1017	DateEnd	“Date of of range of line item.”	The obligation end date is later than the detail’s authorized end date. Change the value of the obligation dateEnd and re-submit.
1018	DateEffective	“Missing or invalid date.”	Change the value of the obligation dateEffective and re-submit.
1019	DateEffective	“Date out of range of line item.”	The obligation effective date is earlier than the detail’s authorized effective date. Change the value of the obligation dateEffective and re-submit.
1020	ClientObligationProv	“Unknown provider liability.”	The patient liability provider could not be found. Change the liability values and re-submit.
1021	CdeServiceLoc	“Missing service location.”	Change the value of cdeServiceLoc and re-submit.
1022	Amt_patnt_liab	“Missing or invalid amount.”	Change the obligation amount and re-submit.
1023	Amt_patnt_liab	“Liability not equal to month amount.”	Change the liability amounts and re-submit.
1024	IdClerkEntry	“Missing or invalid id.”	Change the id and re-submit.
1025	Indicator	“Missing or invalid indicator”	Change the indicator and re-submit.
1026	User_agency	“Invalid agency for clerk.”	Change the agency and re-submit.
1027	AmtPaReq	“Total cannot be less than amount used.”	Change the amount(s) and re-submit.
1028	PaReqEff	“Date below date of service.”	Change the date and re-submit.
1029	UntSvcReq	“Total cannot be less than the number used.”	Change the unit(s) and re-submit.
1030	Procedure	“Benefit not covered for item: n”	Change the procedure, or have the procedure added as a covered benefit.
1031	Fname	“Benefit not covered for item: n”	Change the date and re-submit.
1032	PaReqEnd	“Benefit not covered for item: n”	Change the date and re-submit.
1033	Assignment Code	"Beneficiary not eligible for program."	Change the assignment code and re-submit.
1034	paReqEff	"Program not available when requested."	Change the date and re-submit.
1040	dateEffective	"Provider Obligation start date is missing or invalid."	Change the date and re-submit.
1041	dateEffective	“Provider Obligation start date must be the first day of the month."	Change the date and re-submit.
1042	dateEffective	"Provider Obligation start date is before the Client Obligation start date."	Change the date and re-submit.
1043	dateEffective	"Provider Obligation start date is after the Client Obligation end date."	Change the date and re-submit.
1044	dateEnd	"Provider Oblig. end date must be month-end or same as Client Oblig. end date."	Change the date and re-submit.
1045	Delete_detail	“Unable to delete detail - claim information found: n-n"	A detail cannot be deleted if there any claims against it.
1046	clientObligationProv	"Unable to delete obligation: Unknown provider liability."	Specify a valid obligation.

1047	Delete_detail	“Unable to delete detail – detail not found: n”	Specify an existing detail.
1048	Svc_overlap	"Overlapping procedures: n and n"	Change the date and re-submit
1049	Check_liab_prov_duplicates	"Overlapped obligation for <provider> during <dates>"	Change the date and re-submit.
1050	Procedure	“Benefit is not a known covered benefit: item n“	Change the procedure and re-submit.
1051	Procedure	“Benefit is not for an HCBS program: item n“	Change the procedure and re-submit.
1052	Procedure	“Benefit is not available during the dates specified: item n“	Change the date range and re-submit.
1053	Procedure	“Recipient is not eligible for HCBS benefits: item n“	An HCBS benefit must be added to the recipient’s eligibilties
1054	Procedure	“Recipient is not eligible for HCBS benefits for the date specified: item n“	Change the date range and re-submit.
1055	Procedure	“Recipient is not eligible for the specified benefit: item n“	Change the procedure and re-submit
1056	delete_item	“Unable to delete item - item not found: n“	Specify a different item and re-submit.

2001	clientObligationProv	“Missing patient liability for details.”	The missing data must be entered into the database.
2002	NumPaLineItemDtl	“Record not found.”	The line item detail record is not available. The missing record must be entered into the database.
2003	NumPaLineItem	“Record not found.”	The line item record is not available. The missing record must be entered into the database.
2004	priorAuthorization	“Record not found.”	The prior authorization record is not available. The missing record must be entered into the database.
2005	PaIntText	“Record not found.”	The internal text record is not available. The missing record must be entered into the database.

4???	<fname>	<pa specific error message>	Change the value of <fname> and re-submit.

8001	<value>	“Invalid actionCode specified.”	Report this to the system administrator.
8002	XsdValidateAndPrepare	“Error during preparation.”	Report this to the system administrator.
8003	XsdDatabaseLoad	“Error during update.”	Report this to the system administrator.
8004	Load_target_pa	“Error during database unload.”	Report this to the system administrator.
8005	Load_target_pa	“Missing sak_pa key value.”	Report this to the system administrator.
8006	Root	“Missing or invalid source.”	Report this to the system administrator.
8007	Indicator	“Missing or invalid indicator.”	Report this to the system administrator.
8008	T_covered_benefits	“Benefit table overflow for item: n”	Report this to the system administrator.

9001	CONNECT	<database specific error message>	Report this to the system administrator.
9002	FETCH:<routine>	<database specific error message>	The routine name and the database message should be reported.
9003	CLOSE:<routine>	<database specific error message>	The routine name and the database message should be reported.
9004	CURSOR:<routine>	<database specific error message>	The routine name and the database message should be reported.
9010	Process_obligations	<database specific error message>	The attribute and the database message

			should be reported.
9011	Edit_sak_pat_liab	<database specific error message>	The attribute and the database message should be reported.
9012	New_paLineItem	<database specific error message>	The attribute and the database message should be reported.
9013	New_paLineItemDtl	<database specific error message>	The attribute and the database message should be reported.
9014	Agency_is_valid	<database specific error message>	The attribute and the database message should be reported.
9015	Do_other_pa_info_	<database specific error message>	The attribute and the database message should be reported.
9016	Get_clerk_type	<database specific error message>	The attribute and the database message should be reported.
9017	T_pa_item_dtl_xref	<database specific error message>	The attribute and the database message should be reported
9018	Indicator	<database specific error message>	The attribute and the database message should be reported.
9019	Update_indicator	<database specific error message>	The attribute and the database message should be reporte.
9020	Create_alert: t_cde_alert	<database specific error message>	The attribute and the database message should be reported.
9021	Create_alert: t_re_alert	<database specific error message>	The attribute and the database message should be reported.
9022	Update_preEntryStat	<database specific error message>	The attribute and the database message should be reported.
9023	T_covered_benefit	<database specific error message>	The attribute and the database message should be reported.

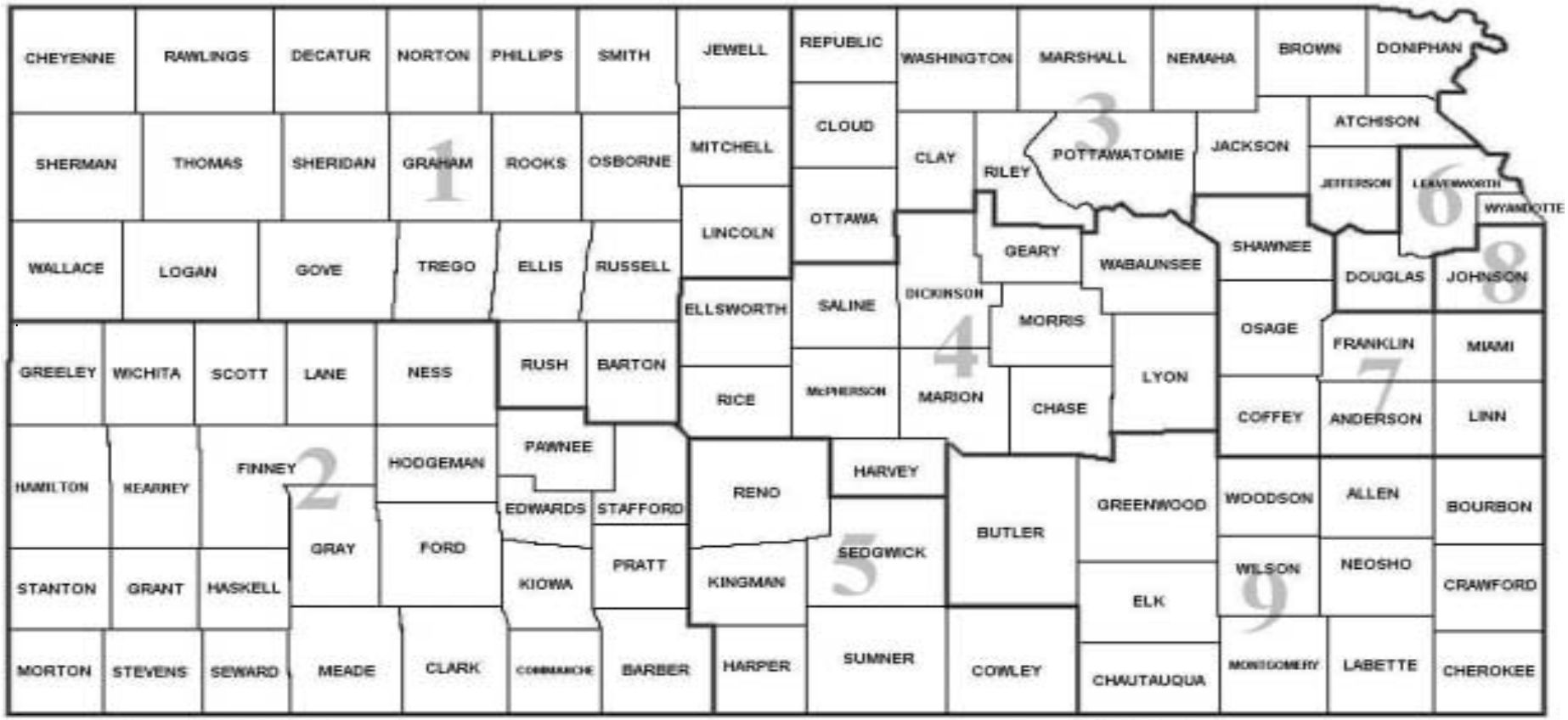
When reporting errors, include all of the information from the message.

Resources

Helpful Phone Numbers

HCBS Help Desk	785-274-5961
New User Applications, EDS Security	785-274-4220
Provider Assistance/Customer Service	800-933-6593
Medicaid Liaisons	
Chanute Area Office	
Rita Stapleton	620-431-5098
Emporia Area Office	
Beth Gates	316-321-4200
Garden City Area Office	
Mary Calzonetti	620-272-5839
Hays Area Office	
Gayle Hanson	785-628-1066 X 264
Hutchinson Area Office	
Cindy Proett	620-663-5731 X 229
Kansas City Area Office	
Monica Sipple	913-279-7689
Lawrence Area Office	
Michelle Swain	785-832-3885
Manhattan Area Office	
Kayla Paige	785-826-8000
Olathe Area Office	
Danny Hewett	913-826-7577
Topeka Area Office	
Kirk Maher	785-296-0396
Wichita Area Office	
Emily Gagnebin	316-337-6350
Marc Madden	316-337-6123

Kansas Medicaid Provider Representative
Territorial Map



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