

# MAC Binder Section 10 – Provider Communications

## Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

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### **1 – Prov Ltr re EPSDT Prov No Chgs\_dte102814:**

DMS no longer requires providers to obtain a separate number to bill for services provided under the EPSDT benefit. All EPSDT provider type numbers that are assigned to Medicaid enrolled providers who deliver services outlined in the Medicaid State Plan will be end-dated effective July 1, 2015.

### **2 – Prov Ltr re Notice to PT45 on Expanded Scope of Covered Svcs\_dte102814:**

Beginning January 1, 2014; the Commonwealth of Kentucky expanded the scope of covered services related to substance abuse and mental health. DMS will be making several changes to ensure compliance with the federally approved SPA. Providers with a provider type 45 number only, if providing services that are now outlined in the SPA such as private duty nursing, OT, PT, or SLT, must enroll and obtain the appropriate provider types to bill these services.

### **3 – Prov Ltr re Fee Increase for Certain Preventive Services\_dte011315:**

Fee increase for certain preventive services provided to fee-for-service members by provider types 64 - Physicians, 65 – Physician Groups, 78 - APRN and 95 – Physician Assistants. This incentive will cover dates of service between January 1, 2015 and June 30, 2016.

### **4 – Prov Ltr re TCM Regulation Changes\_dte020515:**

DMS promulgated new regulations for Targeted Case Management (TCM) services that were effective September 16, 2014. This communication is designed to provide clarification to agencies regarding some of the regulatory changes.

### **5 – Prov Ltr re Telehealth ‘GT’ modifier\_dte022315:**

Notice to providers to refer to the KY Medicaid Billing Manual appropriate for their provider type for instructions as to the proper billing practice for services provided via audio-visual telehealth equipment. Providers must code modifier “GT” in section 24.D of the CMS-1500 to indicate the service was provided through the use of telehealth.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 E Main St 6W-A  
Frankfort, KY 40621  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

October 28, 2014

**TO: Medicaid Providers (PT #45)  
General Provider Letter (PL #A-7)**

**RE: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit**

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. You can learn more about EPSDT at this link <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. In addition, a list of frequently asked questions related to EPSDT is enclosed with this letter.

In the past, the Department for Medicaid Services (DMS) required providers to obtain a separate number to bill for services provided under the EPSDT benefit. However, DMS no longer requires providers to obtain a separate number. You are receiving this letter because you have been identified as a Medicaid enrolled provider who also has a separate EPSDT number. You will no longer need to use the EPSDT number to bill for services that are within your scope of practice that you provide to children under the age of 21. **All EPSDT provider type numbers that are assigned to Medicaid enrolled providers who deliver services outlined in the Medicaid State Plan will be end-dated effective July 1, 2015.**

**If you are a waiver provider and you have an EPSDT number that you use to bill Medicaid for Occupational, Physical, or Speech therapy, you will not be able to use that EPSDT number beginning July 1, 2015.** Therefore, if you wish to continue to provide these therapy services, you must complete an application to enroll and obtain a provider number in the appropriate provider type to deliver those services. The Provider Licensing and Certification Branch will expedite applications for those providers applying for another provider type number. Providers will be given until **June 30, 2015** to enroll as another provider type. Effective July 1, 2015, the EPSDT number will be end-dated regardless of whether or not the provider has enrolled in another provider type.

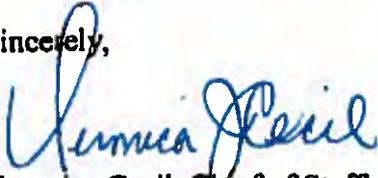
All other requirements related to the EPSDT benefit have not changed. All prior authorization and medical necessity requirements are still in place. If you have questions about the EPSDT program,

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Medicaid Providers (PT #45)  
October 28, 2014

please contact the EPSDT Program Manager at 502-564-9444. For questions regarding enrollment in the Kentucky Medicaid

program, please go to <http://www.chfs.ky.gov/dms/provEnr/> or contact the Provider Licensing Branch at 1-877-838-5085. DMS will work closely with providers to ensure a smooth transition.

Sincerely,

A handwritten signature in blue ink that reads "Veronica Cecil". The signature is fluid and cursive, with the first name being more prominent.

Veronica Cecil, Chief of Staff  
Director, Division of Program Integrity  
Kentucky Department for Medicaid Services

Enclosures

VC/ll/kl

## EPSDT Frequently Asked Questions for Providers

October 28, 2014

### 1. What is EPSDT?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. You can learn more about EPSDT at this link <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

### 2. How do I know if a service is covered under the EPSDT benefit?

If you believe a child under the age of 21 needs a medically necessary service that is not on the current list of benefits or fee schedule for your particular provider type, you should call the child's assigned Managed Care Organization (MCO) or the Department of Medicaid Services if the child is not enrolled in an MCO and request a prior authorization for the service. The EPSDT benefit covers all federally allowable Medicaid services. For example, dental is a federally allowable Medicaid service and Kentucky Medicaid limits dental cleanings to two (2) per year for children under age 21. Any additional dental cleanings that meet medical necessity can be provided through the EPSDT benefit.

### 3. Are there services that EPSDT benefit will not cover?

Yes, there are services that EPSDT will not cover. Services not covered include but are not limited to: respite, environmental items, educational items, experimental services, and supported employment. In addition, EPSDT will not cover the cost of room and board.

### 4. Is there a list of EPSDT benefits that I can review?

No. EPSDT benefits are unique to each child. For a list of federally allowable services and to learn more about EPSDT, you can visit this website:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

### 5. What do I have to do to become an EPSDT provider?

If you are currently enrolled in the Medicaid program, you can provide services to children that are not listed on your fee schedule if the service meets medical necessity criteria. Managed Care Organizations (MCO) may require a prior authorization for services provided under the EPSDT benefit. You will need to check with the child's MCO regarding specific services and prior authorization requirements. If the child is not assigned to an MCO, you must obtain a prior authorization from CareWise. If you are not a provider that is eligible to enroll in the Medicaid

program and you provide medically necessary services to children that meet federal criteria, you should contact the Department for Medicaid Services at 502-564-9444 and inquire about becoming a Medicaid enrolled provider.

**6. How do I file EPSDT claims?**

EPSDT claims are filed just like traditional Medicaid claims. Follow the instructions provided to you by the MCO or the Department for Medicaid Services required for appropriate claim submission. A prior authorization number may be required on the claim form.

**7. What if a request for an EPSDT benefit is denied?**

When a request for service is denied, the child's parents or caregiver will receive a letter outlining the denial reason and explaining the appeal process. It is the responsibility of the parent or guardian to appeal denied services if they believe the service was denied inappropriately. The parent or guardian must follow the process for the appeal as outlined in the denial letter. The appeal must be postmarked within 30 days of the date on the denial letter.

**8. How do I know which children are eligible for the EPSDT benefit?**

Most Medicaid children are eligible for the EPSDT benefit. A few children enrolled in the Kentucky Children's Health Insurance Program (KCHIP) are not eligible for the EPSDT benefit. Children who are identified with a P7 status code are not eligible to receive the EPSDT benefit. If you are unsure about a child's eligibility, you may contact the Department for Medicaid Services or the child's MCO.

**9. How are payments for EPSDT benefits calculated?**

Reimbursement rates are typically based on your MCO contract, a similar service in the Medicaid program, or negotiated.

**10. I have an EPSDT provider number and a Medicaid provider number AND I am not a waiver provider. Do I still need to use both numbers?**

No. In the past, the Department for Medicaid Services required providers who were providing services not listed on their specific fee schedule to have a unique billing number for services provided through the EPSDT benefit. The second number is no longer needed and will be obsolete on July 1, 2015. If you are providing services and billing under the EPSDT benefit, you will need to make sure you meet the provider qualifications for those services as they are outlined in Kentucky's approved State Plan Amendment (SPA) for Medicaid services.

**11. I have an EPSDT provider number and a Medicaid provider number AND I am a waiver provider. Do I still need to use both numbers?**

If you are using your EPSDT provider number to bill for occupational, physical, or speech therapy, you will need to enroll in Medicaid as a provider type that is eligible to provide those therapy services. You will still use your waiver provider number to provide waiver services only.

All EPSDT provider numbers that are being used to deliver and bill Medicaid for services covered under the state plan will be end-dated effective July 1, 2015. This is being done to comply with federal guidelines.

**12. What services were billed under the EPSDT benefit but are now included in Medicaid's state plan and for which I need to meet provider qualifications?**

- Occupational Therapy
- Speech Therapy
- Physical Therapy
- Substance Use Treatment Services
- Private Duty Nursing

If you are providing these services, you must enroll in Medicaid in the appropriate provider type. These services cannot be billed under the EPSDT benefit. The Department will allow providers until June 30, 2015 to obtain the appropriate provider number to bill for these services.

**13. Why did you eliminate the EPSDT number?**

We eliminated the need for a separate EPSDT number to increase timely access to needed services for children and to be in full compliance with federal guidelines.

**14. Can I still use my EPSDT number to bill?**

If you only have an EPSDT number and the services you provide are not outlined in Medicaid's State Plan, you will continue to bill with your EPSDT number. If you have an EPSDT provider number and another Medicaid provider number, you will not bill under your EPSDT number for any services that are outlined in the state plan and for which you are licensed and qualified to provide.

**15. What if I only have an EPSDT number? Do I need to get another Medicaid number?**

If you only have an EPSDT number and the services you provide are not outlined in Medicaid's State Plan, you will continue to bill with your EPSDT number. You can check with the Department if you have any questions.

**16. Will I receive the same reimbursement when I enroll as a provider of state plan services as I receive as an EPSDT provider?**

Reimbursement rates are typically based on your MCO contract, a similar service in the Medicaid program, or negotiated on a case-by-case basis. The same reimbursement is not guaranteed.



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October 28, 2014

**TO:** Medicaid Providers (PT #45)  
General Provider Letter (PL #A-8)

**RE:** Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. You can learn more about EPSDT at this link <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. In addition, a list of frequently asked questions related to EPSDT is enclosed with this letter.

Beginning January 1, 2014, the Commonwealth of Kentucky expanded the scope of covered services related to substance use and mental health. Since the implementation of these expanded benefits and approval of State Plan Amendment (SPA) 13-022, the Department for Medicaid Services (DMS) has evaluated the EPSDT benefit as many services provided under the benefit, such as substance use services, are now State Plan covered services. As a result, DMS will be making several changes to ensure compliance with State Plan requirements related to authorized providers for services outlined in the current federally approved SPA.

You are receiving this letter because you have been identified as only having a Kentucky Medicaid EPSDT number (PT-45). You do not have another Kentucky Medicaid provider number. If you are providing services that are now outlined in the Medicaid State Plan, including but not limited to treatment for substance use, private duty nursing, occupational, physical, or speech therapy, you will need to contact DMS to enroll and obtain the appropriate provider type number to bill for those services.

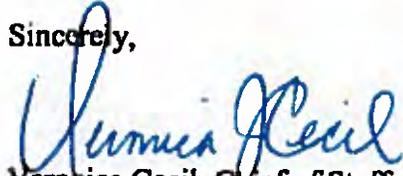
The Provider Licensing and Certification Branch will expedite applications for those providers applying for another provider type number. Providers will be given until **June 30, 2015** to enroll as another provider type. Effective July 1, 2015, the EPSDT number will be end-dated regardless of whether or not the provider has enrolled in another provider type. **Please note certain PT-45 providers will be**



**permitted to keep their current number if providing services not listed in the State Plan, such as services delivered by Prescribed Pediatric Extended Care facilities.**

For questions regarding enrollment in the Kentucky Medicaid program, please go to <http://www.chfs.ky.gov/dms/provEnr/> or contact the Provider Licensing Branch at 1-877-838-5085. If there are questions about the EPSDT program, please contact the EPSDT Program Manager at 502-564-9444. DMS will work closely with providers to ensure a smooth transition.

Sincerely,



Veronica Cecil, Chief of Staff  
Director, Division of Program Integrity  
Kentucky Department for Medicaid Services

Enclosures

VC/ll/kl

**EPSDT Frequently Asked Questions for Providers**  
October 28, 2014

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**2. How do I know if a service is covered under the EPSDT benefit?**

If you believe a child under the age of 21 needs a medically necessary service that is not on the current list of benefits or fee schedule for your particular provider type, you should call the child's assigned Managed Care Organization (MCO) or the Department of Medicaid Services if the child is not enrolled in an MCO and request a prior authorization for the service. The EPSDT benefit covers all federally allowable Medicaid services. For example, dental is a federally allowable Medicaid service and Kentucky Medicaid limits dental cleanings to two (2) per year for children under age 21. Any additional dental cleanings that meet medical necessity can be provided through the EPSDT benefit.

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If you are currently enrolled in the Medicaid program, you can provide services to children that are not listed on your fee schedule if the service meets medical necessity criteria. Managed Care Organizations (MCO) may require a prior authorization for services provided under the EPSDT benefit. You will need to check with the child's MCO regarding specific services and prior authorization requirements. If the child is not assigned to an MCO, you must obtain a prior authorization from CareWise. If you are not a provider that is eligible to enroll in the Medicaid

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All EPSDT provider numbers that are being used to deliver and bill Medicaid for services covered under the state plan will be end-dated effective July 1, 2015. This is being done to comply with federal guidelines.

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- Speech Therapy
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

January 13, 2015

TO: Medicaid Providers  
Physicians (64) – Provider Letter # A-376  
Physicians Group (65) – Provider Letter # A-33  
Nurse Practitioners (78) – Provider Letter # A-96  
Physician Assistants (95) – Provider Letter # A-95

RE: Fee Increase for Certain Preventive Services Provided to Fee-for-Service Members

Beginning January 1, 2013, payments to Medicaid providers for primary care services were increased to 100% of Medicare under the Affordable Care Act (ACA). The increased payments were federally funded and are set to sunset on December 31, 2014. In Kentucky, over 200,000 children and nearly 50,000 adults received preventive services during this two year period of increased payments. We certainly recognize the importance of preventive services in reducing emergency room visits, lowering overall costs and increasing quality outcomes. As such, we want to continue incentivizing providers to provide preventive care to our fee-for-service Medicaid members by increasing fees to certain services, subject to CMS approval. **These payments apply only to claims for services rendered to fee-for-service members by provider types 64, 65, 78 and 95.** The table below represents the services that are eligible for this program. Only services provided between January 1, 2015 and June 30, 2016 are eligible to be reimbursed at the enhanced rate.

Preventive Service	
Childhood Immunizations - DtaP	Childhood Immunizations - Hep B Catch-Up 11-15 years old
Childhood Immunizations - DtaP - Hep B - IPV	Childhood Immunizations - Tdap, DtaP for children over 7 years old
Childhood Immunizations - DtaP - HiB - IPV	Intranasal Flu Vaccine live
Childhood Immunizations - IPV	EPSDT/Well Child Visits in First 15 months of Life
Childhood Immunizations - MMR	Breast Cancer Screening
Childhood Immunizations - MMR-V	Cervical Cancer Screening

Childhood Immunizations - HiB	Flu Vaccine
Childhood Immunizations - HiB - HepB	HPV Vaccine for Female Adolescents
Childhood Immunizations - Hepatitis B	Colorectal Cancer Screening
Childhood Immunizations - Varicella (VZV)	After Hours Services
Childhood Immunizations - Pneumococcal Conjugate	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Childhood Immunizations - Hepatitis A	Weight Assessment and Counseling for Nutrition/Physical Activity – Children and Adults
Childhood Immunizations - Rotavirus	Controlling High Blood Pressure
Blood Lead Screening	

Specific billing instructions and corresponding rates can be found on the Fee Schedule page of the Kentucky DMS website, <http://www.chfs.ky.gov/dms/fee.htm>, under “Medicaid Preventive and Wellness Enhanced Fee Schedule.” Please contact Provider Services at 1- 855-824-5615 if you have any questions.

Sincerely,

  
Lawrence Kissner, Commissioner  
Kentucky Department for Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

February 5, 2015

**TO: Medicaid Providers  
Community Mental Health Centers (30) – Provider Letter #A-100**

**RE: Targeted Case Management**

**Dear Community Mental Health Center (CMHC) Provider:**

The Department for Medicaid Services (DMS) promulgated new regulations for Targeted Case Management (TCM) services that were effective September 16, 2014. These regulations include: 907 KAR 15:040E, 907 KAR 15:045E, 907 KAR 15:050E, 907 KAR 15:055E, 907 KAR 15:060E, and 907 KAR 15:056E. This communication is designed to provide clarification to your agency regarding some of the changes contained in these regulations.

Your agency should discontinue the use of your old TCM provider numbers (Provider Type 27 and 28) and the procedure code T2022 by March 1, 2015. DMS will discontinue these provider types and the T2022 procedure codes effective close of business on June 30, 2015. Should you have any questions or concerns regarding resubmittal of previously paid claims, please contact the appropriate Managed Care Organization (MCO). Your agency should bill TCM services through your Provider Type 30 number. All TCM services are limited to one (1) unit per member, per month. Below, please find the established rates and modifiers for TCM services provided through traditional Medicaid:

<b>Procedure Code</b>	<b>Code Description</b>	<b>Modifier</b>	<b>Established Rate</b>
T2023	Targeted Case Management – Individuals with Substance Use Disorder as defined in 907 KAR 15:040E, per month	HF	\$334.00
T2023	Targeted Case Management – Individuals with co-occurring Severe Mental Illness (SMI), Severe Emotional Disability (SED) or Substance Use Disorders and Chronic or Complex Physical Health Issues as defined in 907 KAR 15:050E, per month	TG	\$541.00



T2023	Targeted Case Management – Individuals with Severe Emotional Disability (SED) as defined in 907 KAR 15:060E, per month	UA	\$334.00
T2023	Targeted Case Management – Individuals with Severe Mental Illness (SMI) as defined in 907 KAR 15:060E, per month	HE	\$334.00

These regulations limit a TCMs caseload to a total of 25 clients regardless of services being provided. The only services that may be provided and not counted toward the caseload include crisis services and screenings. Based on input from the Kentucky Association of Regional Mental Health-Mental Retardation Programs (KARP), DMS is allowing a transitional period to allow your agency to come into compliance with the regulatory caseload limitation. Your agency shall comply with the 25 client caseload limitation no later than October 1, 2015.

DMS has received inquiries regarding the denial of claims when the Place of Service (POS) billing code 99 is used. Per the provider letter sent to your agency on June 3, 2014 POS codes 27, 28 and 99 are no longer valid for reimbursement. The appropriate POS codes for your agency include:

- |                       |                               |                                     |
|-----------------------|-------------------------------|-------------------------------------|
| 03 – School           | 13 – Assisted Living Facility | 33 – Personal Care Home             |
| 04 – Homeless Shelter | 14 – Group Home               | 53 – Community Mental Health Center |
| 11 – Office           | 15 – Mobile Crisis            |                                     |
| 12 – Home             | 18 – Worksite                 |                                     |

You may download a copy of this letter from <http://www.chfs.ky.gov/NR/rdonlyres/176FE780-1281-439E-BDFC-2F19585364F7/0/CMHCPProviderLetterA972.pdf>

Additionally, DMS has received numerous inquiries regarding the provision of TCM to a client who is also receiving case management from one of the Medicaid Waiver Programs. The Centers for Medicare and Medicaid Services have determined this constitutes as a duplication of service. If a client is actively participating in one of the Kentucky Medicaid Waiver Programs, TCM services shall not be provided in addition to waiver case management. If your agency has clients in the TCM and Kentucky Medicaid Waiver Programs, your agency should transition all case management duties to the waiver case manager no later than March 1, 2015.

Should you have any questions regarding this information, please email DMS at [DMS.issues@ky.gov](mailto:DMS.issues@ky.gov).

Sincerely,



Lisa D. Lee, Commissioner

cc: Mary Begley, Commissioner, Department for Behavioral Health, Intellectual and Developmental Disabilities

LDL/KEH



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

February 23, 2015

**TO:** All Medicaid Providers  
Provider Letter #A-99

**FROM:** Lisa Lee, Commissioner, Department for Medicaid Services

**RE:** Telehealth GT Modifier

Dear Medicaid Provider:

Kentucky Medicaid reimburses for certain Medicaid State Plan services provided via audio-visual telehealth equipment pursuant to 907 KAR 3:170. In order to identify that a service was provided through the use of telehealth, providers must code the service using a "GT" modifier on the CMS-1500 form. The "GT" modifier should be indicated in section 24.D. under the box marked "Modifier." Please see the Kentucky Medicaid billing manual appropriate for your provider type at <http://www.kymmis.com/kymmis/Provider%20Relations/billingInst.aspx> for additional instructions.

If you have any questions, please contact Provider Services at 1-855-824-5615 if you have any questions.

Sincerely,

Lisa D. Lee, Commissioner  
Department for Medicaid Services

LL/LH