

Kansas Administrative Regulations

Kansas Department for Children and Families

Article 5.—Provider Participation, Scope of Services, and Reimbursements for the Medicaid (Medical Assistance) Program

30-5-70. Payment of medical expenses for eligible recipients.

(a) Payment for covered services shall be made only to those providers participating in the program pursuant to K.A.R. 30-5-59. The only exceptions shall be pursuant to K.A.R. 30-5-65.

(b) Each program recipient shall be eligible for the payment of specific medical expenses as follows:

(1) Payment of Medicare (title XVIII) premiums and deductibles and co-insurance amounts for services covered in the medicaid program. Recipients who are ineligible for program coverage because they have a spenddown shall be eligible for the payment of the Medicare (title XVIII) premium expense. For cash recipients, including SSI recipients, who are age 65 or older, payment of the Medicare (title XVIII) premium shall begin with the month of approval for medicaid, excluding any months of prior eligibility. For recipients under age 65 who are eligible for Medicare after receiving retirement and survivor's disability insurance for 24 consecutive months, payment of the Medicare (title XVIII) premium shall begin with the 25th month. For all other recipients, payment of the Medicare (title XVIII) premium shall begin with the second month following the month of approval for medicaid, excluding any months of prior eligibility;

(2) payment of premiums of health maintenance organizations that are approved by the agency or premiums of group health plans offered by the recipient's employer if the agency has determined that this plan is cost-effective;

(3) payment of other allowable medical expenses incurred in the current eligibility base period in excess of any co-pay or spenddown requirements;

(4) payment for services rendered to a person who is mandated to receive inpatient treatment for tuberculosis and who is not otherwise eligible for participation in the program. Coverage shall be limited to services related to the treatment for tuberculosis;

(5) payment for services in excess of medicaid/ medikan program limitations for foster care and adoption support recipients, when approved by the agency; and

(6) payment for covered medical services provided to an individual participating in the KanWork program. A monthly cost-sharing amount for medical services shall be paid by each individual participating in the KanWork program when required.

(c) The scope of services provided to recipients and the payment for those services shall be as set forth in articles 5 and 10 of this chapter, subject to the following limitations.

(1) Payment for a particular medical expense shall be denied if it is determined that any one of these conditions is met:

(A) The recipient failed to utilize medical care available through other community resources, including public institutions, veterans administration benefits, and those laboratory services that are available at no charge through the state department of health and environment.

(B) A third party liability for the medical expense has been established and is available.

(C) The recipient fails to make a good faith effort to establish a third party liability for the medical expense or fails to cooperate with the agency in establishing the liability. Payment of a medical expense may be delayed pending the outcome of a determination concerning third party liability.

(D) The expense is not covered or is only partially covered by an insurance policy because of an insurance program limitation or exclusion.

(E) The recipient failed to notify the provider of services of the recipient's eligibility for the program.

(F) The service is cosmetic, pioneering, or experimental, or is a result of complications related to these procedures.

(G) The service is related to transplant procedures that are not covered by the medicaid/medikan program.

(H) The service was provided by a provider not designated as a lock-in provider for any recipient who is locked into designated providers due to abuse, unless the provider

has a written referral from a designated provider or unless the service was an emergency service.

(I) The service was provided by a provider not designated as the primary care case manager for any recipient who is enrolled in the primary care case manager program, unless the provider has a written referral from the designated provider or unless the service was an emergency service.

(J) The service was covered in a health maintenance organization plan for any recipient enrolled in a health maintenance organization.

(K) The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the medicaid/medikan program.

(L) The service exceeds the limitations defined by the program policies.

(2) Payment for out-of-state services shall be limited to the following:

(A) Payment on behalf of recipients if medical services are normally provided by medical vendors that are located in the bordering state and within 50 miles of the state border, except for community mental health center services, alcohol and drug abuse services, or partial hospitalization services;

(B) emergency services rendered outside the state;

(C) nonemergency services for which prior approval by the agency has been given. Authorization from the agency shall be obtained before making arrangements for the individual to obtain the out-of-state services;

(D) services provided by independent laboratories; and

(E) medical services provided to foster care recipients and medical services in excess of the limitations of the state of residence, when approved by the Kansas department of social and rehabilitation services and within the scope of the adoption agreement for those for whom Kansas has initiated adoption support agreements.

(3) The scope of services for adult non-medicaid (non-title XIX) program recipients shall be limited as set forth in K.A.R. 30-5-150 through 30-5-172.

(d) Payment for medical services shall be made, at the discretion of the secretary, when it has been determined that an agency administrative error has been made.

(e) This regulation shall take effect on and after October 1, 1998.

(Authorized by and implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended, T-84-8, April 1, 1983; amended May 1, 1983; amended, T-84-9, May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended May 3, 1993; amended July 19, 1996; amended Oct. 1, 1998.)

***** Authenticated Kansas Administrative Regulation *****