# K Plan Ancillary Services
# Frequently Asked Questions

- ***How are providers for home modifications recruited?***
  - In general, consumers or case managers request contractors to bid on a project.
  - If a contractor does not have a Medicaid provider number, we will ask them to submit the provider enrollment forms. We attempt to enroll all providers even if they are not selected to perform a specific project.
  - Please remember that it may take a few weeks to enroll providers because we need to check their qualifications and make sure they are in good standing. We also need to obtain SSNs and other detailed information and some vendors / contractors need to be encouraged to provide that information. If everything is complete, a provider number is usually assigned within 2 weeks.

- ***What if we don't have any providers or less than 3 in our area?***
  - If you cannot find enough enrolled providers to offer a bid, submit the bids you or the consumer were able to obtain and explain why you were unable to obtain more.

- ***Provider Enrollment Forms – Who should start the process?***
  - Local offices can use the Provider Enrollment Agreement Form (PEA) when they solicit or receive a bid from a non-enrolled provider. Having the provider submit the form at the same time as the request will speed things up. Additionally, if the provider refuses to complete the PEA you will know that you need to find another provider.
  - We recommend that you explain that we pay 100% of the service ***after*** the work is done. Federal law (CFRs) prohibit us from paying prior to completion of the project. If a provider is unwilling or unable to accept this, they should not be enrolled nor should you request a bid from them.
  - Submit PEAs to: APD.Providerenrollment@state.or.us
  - PEA Form is available at: http://www.dhs.state.or.us/spd/tools/cm/K_Plan/index.htm

- ***What happens if we cannot find a provider willing to wait for payment (i.e., they want to be paid up-front)?***
    - Explain to the provider that federal law prohibits us from making a down payment. However, once we receive a final invoice, we will generate a payment within 7 days.

- ***Can you explain when we need to submit a written denial for DME?***
    - We must ensure that we are not duplicating services that are part of Medicare or Medicaid health benefits. This is a requirement in CFRs and is one of the assurances APD must make to the Centers for Medicare and Medicaid Services (CMS).
    - We endeavor to prevent cost-shifting to K Plan Ancillary Services when an item or service should be the responsibility of the health plan or another payor.
    - OHA has provided flexible funding to the CCOs. This funding is intended to support needs that are not normally covered by Medicaid. If there is a connection to a medical issue, please explore options with the CCO first.
    - Non-covered DME or assistive technology items do not need a written denial. Please consult with the K Plan Policy Analyst if you have questions about this, and if applicable, please document on the 3406.

- ***OHP denied a DME request, do we have to wait for the appeal?***
    - No, an initial denial is sufficient.

- ***Are hearing notices for consumers required when we deny a K Plan request?***
    - Yes, if the consumer requested the service, written denials with hearings rights are required. Central Office will provide rule citations and denial rationale to the case manager.
    - If the case manager determined that the service would help and Central Office denies the request, a written denial notice to the consumer is not necessary.

- ***What should we do when we have an urgent request for KPlan? For example, when placement or housing is at risk? Or client safety is an issue?***
    - You can flag the case with a red flag (in Outlook) and use the term urgent in the subject line. Our goal is to respond to urgent requests within 1-2 business days.

- Incomplete requests, assessments that do not identify the need, and non-enrolled providers will slow the review process.

- ***Please explain the entire process (start to end) in Salem once the KPlan request is received.***
    - It depends on the item or service requested. Generally, the full process is as follows:
        - The request is reviewed to ensure it meets Rule, is complete, matches the assessment, etc.
        - If so, the request is submitted to management for review.
        - If not, staff requests additional information, consent forms, an updated assessment, etc.
    - If management approves the request, the K Plan Program Analyst notifies the case manager and narrates the decision.

- ***What is considered a reasonable time frame to receive a response back from KPlan once a request has been sent?***
    - If the request is complete and matches the assessment, the turnaround time is generally 2 weeks.
        - Please follow up if you have not received a response within 2 weeks by emailing K Plan Requests with "status check" in the subject line. Please include the consumer's name, prime, and date and type of request. Please do not resubmit the request a second time.

- ***Do the staff that work the K Plan read narration in Access?***
    - Yes, but we primarily rely on the assessment. Information in narration that supports the request should be documented on the 3406.
    - The assessment must define the need because the K State Plan Amendment requires that the service match an assessed need.

- ***What is considered a reasonable time frame for payment to go out to providers?***
    - Once we receive the bill, we generally pay within 7 days. However, we often do not receive the invoice or verification that the work was completed, and that stalls the payment process.

    - If you are submitting an invoice, please indicate “Invoice” in the subject line of the email.

- ***What if our DME providers are only giving us verbal/over the phone quotes? Do we have to have 3 written quotes on equipment or is verbal okay?***
    - CFRs and OARs require written bids. Verbal quotes are not sufficient.