2026

# Provider manual

Resources, policies and procedures at your fingertips

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Aetna Better Health® of Kentucky

AetnaBetterHealth.com/Kentucky

Aetna/2350 10-01-25 (1/26)

# Quick Reference Guide (Important Phone Numbers)

| Department | Phone Number |
|---|---|
| Member Services | **1-855-300-5528 (TTY: 711)** |
| Behavioral Health Crisis Hotline | **1-888-604-6106 (TDD: 1-866-200-3269, TTY: 711)** |
| Network Relations | **1-855-300-5528** |
| Prior Authorization<br>**see additional below for **SKY** specific members:*<br><br>You may also submit requests online through CoverMyMeds, Surescripts, or CenterX ePA portals | **Medical:**<br>Phone **1-888-725-4969**<br>Fax **1-855-454-5579**<br><br>**Behavioral Health:**<br>Phone **1-855-300-5528**<br>Fax **1-855-301-1564**<br><br>**Psychological Testing: 1-844-885-0699**<br><br>**Pharmacy:**<br>**MedImpact**<br>Phone: 1-844-336-2676<br>Fax: 1-858-357-2412<br><br>**https://kyportal.medimpact.com/provider-forms/provider-forms** |
| Prior Authorization – ***SKY** Members Only* | **SKY Medical** Fax: 1-833-689-1422<br>**SKY Concurrent Review** Fax: 1-833-689-1423<br>**SKY Behavioral Health** Fax: 1-833-689-1424 |
| Concurrent Review Inpatient Medical Requests | Fax: **1-855-454-5043**<br>Phone: **1-888-470-0550**<br>Submission also available through Availity |
| Retro Review | Phone: **1-888-470-0550,** Opt. 8 Fax: **1-855-336-6054** |
| Dental (Skygen)<br>Vision (Avesis) | **1-855-454-0061**<br>**1-855-214-6777** |
| Radiology/Pain Management (eviCore) | **1-888-693-3211** |
| Pharmacy (MedImpact) | **1-800-210-7628** |
| Fraud & Abuse | **1-855-300-5528** |
| Office Location | Aetna Better Health of Kentucky<br>9900 Corporate Campus Drive, Suite 1000<br>Louisville, KY 40223 |
| Claims Information | EDI Payor ID (Claim) #128KY<br>PO Box 982969<br>El Paso, TX 79998-2969 |
| Claims Inquiry Claims Research (CICR) | **1-855-300-5528** |
| Member Eligibility Verification at KYHealthChoices.net | **https://public.kymmis.com** |
| Case and Disease Management Referrals | **1-888-470-0550** |
| Returned Checks and Refunds | Aetna Better Health of Kentucky Attn: Finance<br>P. O. Box 842605<br>Dallas, TX 75284-2605 |
| Complaints Appeals Address | Aetna Better Health of Kentucky<br>Attn: KY Appeals & Grievances<br>PO Box 81040<br>5801 Postal Rd<br>Cleveland, OH 44181<br>Fax: 1-855-454-5585<br>email: **KYAppealandGrievance@aetna.com** |
| Website | **AetnaBetterHealth.com/Kentucky** |
| Availity Portal | **https://apps.availity.com/availity/web/public.elegant.login** |

# **Welcome** to your provider manual

Welcome to Aetna Better Health® of Kentucky. We are pleased that you are part of our network of providers. We are committed to providing accessible, high-quality service to our members in Kentucky, and we realize this can only happen with your partnership. We are here to serve you as you work towards making the lives of all Kentuckians healthy and strong.

You have told us what's important to you. And we listened. Through your feedback, we continually update this manual to make it easier for you to work with us. This manual applies to any health care provider, including physicians, health care professionals, hospitals, facilities, and ancillary providers, except when indicated otherwise. It includes policies and procedures. Aetna may add, delete, or change policies and procedures, including those described in this manual, at any time. Please read this manual carefully. Your agreement requires you to comply with Aetna policies and procedures including those contained in this manual.

**Visit** **AetnaBetterHealth.com/Kentucky/index.html** or our provider portal, **Availity.com**, to find additional policies, procedures, and information. You will find programs we offer that could benefit your Aetna patients, plus, electronic transaction tools that save you time. And, of course, you will find our contact information, so you can reach us whenever you need to.
You will also find information on how to get your claims paid faster, your pre-authorization requests processed promptly, and your administrative burdens lessened. We want you to find what you need, quickly and efficiently.

## Have questions? Contact us via

**AetnaBetterHealth.com/Kentucky/providers/contact-us.html**

— we are here to help.

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# Overview

## Department for Medicaid Services

Kentucky Medicaid is a state and federal program authorized by Title XIX of the Social Security Act to provide health care for eligible low-income residents including children, families, pregnant women, the aged, and the disabled. Eligibility is determined by several factors, including family size, income, and the federal poverty level. Medicaid offers several programs and services directed at specific eligibility and medical needs.

It is important to note that Aetna Better Health does not determine eligibility for Medicaid. Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Community Based Services (DCBS) offices located in each county of the Commonwealth.

Kentucky Medicaid members are given the option to participate in an annual open enrollment period where they may choose to join one of the MCOs contracted by DMS (Department for Medicaid Services). New members are also given 90 days after the time of enrollment to change MCOs. DMS is responsible for this process and maintains all member eligibility information in their KyHealthNet online system.

## About Us

Aetna Medicaid ‘s success comes from more than 30 years of experience serving high-risk populations, building relationships with local partners, integrating the delivery of clinical care, and developing innovative programs and technology. We provide services for over 2.8 million members with a large national presence. Our managed care strategies and tools are member centered and have a proven record of improving health outcomes. Working together with providers and local government, we believe we can help create a better health care system for our members.

At Aetna Better Health of Kentucky, we believe in improving every life we touch as good stewards to those we serve.

## Service Area in Kentucky

Aetna Better Health of Kentucky serves members and providers in all 120 counties in Kentucky.

## Our Values

At Aetna, we conduct business using a clear, strongly held set of core beliefs that reflect who we are and what you can expect from us. Our values carry through our thoughts and actions every day, inspire innovation in our products and services, and drive our commitment to excellence in all we do.

## Quality Assured

In 2024, more Medicaid-eligible Kentuckians stayed with or switched to Aetna Better Health of Kentucky. Aetna achieves excellence in health care quality by empowering members across the care continuum to engage in their physical and psychosocial well-being and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities.

## Model of Care

Our model of care offers an integrated care management approach, which offers enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, care management, and coordination efforts applied to address member needs result in a comprehensive and integrated plan of care for members.

Our program's combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- To improve access to affordable care
- To improve coordination of care through an identified point of contact
- To improve seamless transitions of care across healthcare settings and providers
- To promote appropriate utilization of services and cost-effective service delivery

Our efforts to promote cost-effective health service delivery include, but are not limited to, the following:

- Review of network for adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services

Many components of our integrated care management program influence member health.
These include:

- Comprehensive member assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and to allow enrollees to reside in the least restrictive environment possible.
- Assessments and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Case manager referrals and predictive modeling software that identify enrollees at increased risk of functional decline, hospitalization, and emergency department visits.

## About this Manual

This provider manual serves as a guide to the policies and procedures governing the administration of **Aetna Better Health of Kentucky**. It is an extension of and supplement to the **Provider Agreement** between Aetna Better Health of Kentucky and contracted practitioners and providers delivering health care services to our members.

Throughout this manual, you will find answers to common questions regarding operations, expectations, and resources available to support your practice. Aetna Better Health of Kentucky retains the right to add to, delete, or otherwise modify this manual. All revisions will be binding and will comply with applicable **statutory, regulatory, contractual, and accreditation requirements**.

As updates occur, we will communicate changes through:

- Provider letters
- Email notifications
- The provider website
- Newsletters
- Your Network Relations Team

We are committed to improving the usefulness of the tools and information we make available to our providers. Your feedback is important to us. Please send comments, suggestions, or questions directly to the Network Relations team at **KYProviderRelations@aetna.com**.

# Provider Experience

## Provider Experience

Our approach to working with providers is based on our **Aetna Better Together** philosophy. Provider engagement and collaboration is a cornerstone of our processes and critical to achieving improved provider experience. Our highly trained and experienced Network Relations leadership and staff have over 175 years of combined experience working for Kentucky Providers.

Our Network Managers are based in the communities they serve, fostering a higher level of responsiveness and personalized relationships. These locally based Network Managers engage with providers through a variety of mechanisms designed to provide proactive, prompt, and collaborative communications.

We pledge to:

- Develop strong relationships with providers, staff, and community
- Provide excellent service to both our internal and external customers
- Commit to be leaders of positive and innovative change

Aetna's comprehensive Provider Experience functions include all services, tasks, and requirements under the model contract. Below is a list of some provider engagement activities:

- New provider orientations offered on site, or webinar based
- Site visits (face-to-face)
- Training webinars and targeted on-site training
- HEDIS® toolkits
- Network Notices and our TIP Tuesday campaign
- Newsletters
- Committees, workgroups, and forums

Providers can access their Network Managers' contact information by scanning this QR code or on the Aetna Better Health website using this link**:** AetnaBetterHealth.com/Kentucky/providers/index.html

Provider can also access previous provider communication, newsletters, and updates at the Aetna Better Health website using this link; AetnaBetterHealth.com/Kentucky/providers/newsletters.html

You can also reach us at KYProviderRelations@Aetna.com with any questions.

## Provider Orientation

Once credentialing approval is granted by **Aetna Better Health**, a **Network Manager** will contact the new provider by telephone or email to welcome them to the network. This initial communication will include:

- A welcome letter for new contracts
- A copy of the executed contract
- A link to the **Provider Manual**
- Details for scheduling the **New Provider Orientation**

**Orientation Options:**
New Provider Orientations are offered both **on-site** and via **webinars** to accommodate provider preferences.

**Orientation Content:**
During the session, providers receive comprehensive information on key topics, including but not limited to:

- Website overview
- Review of access and availability standards
- Provider enrollment requirements
- Taxonomy/NPI education
- Healthcare Effectiveness and Data Information
- Advance Directives
- Family Planning
- Population health programs and specific information to address the provider's needs
- Fraud, Waste & Abuse
- Claims submission guidelines
- Cultural sensitivity standard review
- Availity overview/enrollment

## Site Review

**Network Managers** conduct annual site visits with hospitals, primary care physicians, and specialists. These visits take place at the provider's location to verify compliance with all contractual requirements and ensure adherence to quality standards. Following each visit, **Provider Experience leadership** sends an email survey to gather feedback and confirm that the visit addressed the provider's needs.

## Claims Assistance:

Providers may request a meeting with their assigned Network Manager regarding any clean claim under KRS 304.17A-700 to 304.17A-730. This includes clean claims that remain unpaid for forty-five (45) days or more and involve individual or aggregate amounts exceeding $2,500.00.

## Confidentiality

Confidential information is any information revealed through a confidential relationship. It includes communication between the member, the provider, and/or other clinical persons involved in the member's medical, psychiatric, and/or substance use care.

## Provider Identifiers

All participating providers are required to have a unique Kentucky Medicaid provider number and a National Provider Identifier (NPI). Aetna Better Health verifies the current Kentucky Medicaid provider status by reference to data provided by the Department. Aetna Better Health may deny reimbursement for claims for covered services if it determines that the provider does not have a current Kentucky Medicaid provider number at the time it adjudicates the claim.

## Provider Responsibilities

### Responsibilities of the Primary Care Provider

Our primary care providers (PCP) serve as the cornerstone of our Aetna Better Health provider network. You play a vital role in ensuring that each of our members has a medical home and access to necessary health care, which provides continuity and coordination of care. Aetna will assist you in fulfilling this role by providing training on topics, such as how to screen for behavioral health disorders, how to refer for behavioral health services, and behavioral health intervention techniques. Aetna Better Health PCPs (Primary Care Physician) include:

- Registered nurses who are advanced practice registered nurses with a specialty in family practice, Pediatric practice, and/or OB/GYN practice
- Physician assistants
- Primary care clinics
- Physicians with a specialty in family and general practice, pediatrics, OB/GYN, and/or internal medicine
- Institutions with teaching programs and primary care provider teams comprised of residents and a supervising faculty provider may provide primary care services. The lead provider for member assignments must be the attending physician, not a resident.

**The following is an overview of the responsibilities that our PCP assumes in the management of a member's health care needs:**

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at https://public.kymmis.com**.** Please contact Aetna Better Health Customer Service at **1-855-300-5528** if assistance is needed.
- Verify member's status as a Supportive Managed Care member and determine the providers to which a member is restricted for services.
- Promote access to quality care by using participating Aetna Better Health specialists, hospitals, and ancillary providers.
- Make referrals for specialty care and other medically necessary services to participating providers and obtain prior authorization from Aetna Better Health before using out-of-network providers, when necessary.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Contact Aetna Better Health for those services that require authorization prior to the services being performed.
- Coordinate with Aetna Better Health case and disease management staff in developing care plans for members enrolled in care management.
- Conduct behavioral health screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or substance use problems.
- Exchange information between behavioral health care and primary care practitioners,

medical/surgical specialists, organizational provider, or other relevant medical delivery systems.

- Approve appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings.
- Appropriate utilization of psychopharmacological medications and adherence to consistent guidelines for prescribing by behavioral and medical practitioners.
- Provide any clinically appropriate behavioral health services within the scope of their practice.
- Screen and manage patients with co-existing medical and behavioral conditions.
- When a member changes PCP, the medical records or copies of medical records shall be forwarded to the new PCP or partnership within ten (10) days from receipt of request. The PCPs shall have members sign a release of medical records before a medical record transfer occurs.

**Responsibilities of the Specialist and Consulting Practitioners**

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at https://public.kymmis.com**.** Please contact Aetna Better Health Customer Service at **1- 855-300-5528** if assistance is needed.
- Verify member's status as a Supportive Managed Care member and determine the providers to which a member is restricted for services.
- Conduct behavioral health screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or substance use problems.
- Specialists must report preliminary diagnosis and treatment plans to the member's PCP within two (2) weeks from the date of the first office visit. Two (2) weeks after treatment or evaluation is complete, the specialist must provide the PCP with a detailed member summary.
- Each subsequent encounter also should result in written communication within two (2) weeks.
- This and other medical record information transferred by Aetna Better Health participating providers should be done in a confidential, timely, and accurate manner consistent with state and federal law. Neither Aetna Better Health nor the member shall be charged for such record transfer.

**Responsibilities of the Hospital Provider**

The following is an overview of the responsibilities a hospital provider assumes when providing care to Aetna Better Health members:

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at https://public.kymmis.com. Please contact Aetna Better Health Customer Service at **1-855-300-5528** if assistance is needed.
- Verify member's status as a Supportive Managed Care member and determine the providers to which a member is restricted for services.
- Conduct behavioral health screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or substance use problems.

- Exchange information between behavioral healthcare and primary care practitioners, medical/surgical specialists, organizational provider, or other relevant medical delivery systems.
- For members presenting to the hospital Emergency Department (ED) with a non-emergency condition, determine if the member is enrolled in the Supportive Managed Care program. As required by Kentucky Medicaid regulations, Aetna Better Health does not cover non-emergency services provided to Supportive Managed Care members if provided by a hospital other than the member's Supportive Managed Care hospital.
- Obtain prior authorization for services in accordance with the Prior Authorization List
- Participate in concurrent review process and discharge planning process.
- Promote access to quality care by directing members to use Aetna Better Health network providers, with the approval of member's PCP or directing provider.
- Coordinate with the member's PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Provide all the health care services and supplies that are medically necessary, that are available by the provider and which the provider is licensed to provide to members, and that are covered under the terms of the applicable benefit plan.
- Provide covered services in accordance with the terms of their applicable Participating Provider Agreement and the bylaws, rules, regulations, policies, and procedures of the provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with accepted medical and surgical practices in effect at the same time of service.
- Submit Emergency Department medical records to the member's PCP.
- Submit documentation including, but not limited to, medical records, itemized bills, and invoices to support the authorization and billing of services, as requested.
- Participating providers may not discriminate against Aetna Better Health members by providing treatment differently from other persons receiving services.

**Responsibilities of the Ancillary Provider**

The following is an overview of the responsibilities an ancillary provider assumes when providing care to Aetna Better Health members:

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at www .https://public.kymmis.com. Please contact Aetna Better Health Customer Service at **1-855-300-5528**, if assistance is needed.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Promote access to quality care by directing members to use Aetna Better Health network providers.
- Coordinate with the member's PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Maintain a comprehensive and legible medical record and make such records available upon request.
- Provide all the health care services and supplies that are medically necessary, that are available by the provider and which the provider is licensed to provide to members, and that are covered under the terms of the applicable benefit plan.

- Provide covered services in accordance with the terms of their applicable participating provider agreement and the bylaws, rules, regulations, policies, and procedures of provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with accepted medical and surgical practices in effect at the time of service.
- Participating providers may not discriminate against Kentucky Medicaid managed care members by providing treatment differently from other persons receiving services.

**Responsibilities of Behavioral Health Care Providers**

- Behavioral Health Providers may only provide physical health care services within the scope of their licenses.
- Behavioral Health providers will deliver services in a culturally competent manner with the application of a health equity lens to the provision of services.
- Ensure the use of the most current version of the DSM and document the DSM diagnosis and assessment/outcome information in the member's medical record.
- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at www.https://public.kymmis.com. Please contact Aetna Better Health Customer Service at **1-855-300-5528**, if assistance is needed.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Promote access to quality care by directing members to use Aetna Better Health network providers.
- Coordinate with the member's PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Provide health care services and supplies that are medically necessary, that are available by the provider and which the provider is licensed to provide to members, and that are covered under the terms of the applicable benefit plan.
- Provide covered services in accordance with the terms of their applicable participating provider agreement and the bylaws, rules, regulations, policies, and procedures of provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with accepted medical and surgical practices in effect at the time of service.
- Participating providers may not discriminate against Kentucky Medicaid managed care members by providing treatment differently from other persons receiving services.
- Communication between behavioral health care providers and the member's PCP helps to ensure that members receive coordination of care. The sharing of clinical information promotes quality health care and a comprehensive treatment plan to assess co-existing medical conditions, medication interactions, or other medical concerns.
- Refer members with known or suspected and untreated physical health problems or disorders to such member's PCP for examination and treatment, with the member's or the member's legal guardian's written consent.
- Provide initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the member's PCP, with the member's or the member's legal guardian's consent.
- Provide targeted or intensive case management services as medically necessary to members with SMI and co-occurring conditions who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility.
    - Ensure the Case Manager is assigned prior to or on the date of discharge.
    - Participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws.

- Assist members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP or other similar assistance programs).

## Provider Rights

- Providers have the right to receive information about Aetna Better Health of KY, its services, its policies and procedures, practitioners and providers, and member rights and responsibilities.
- Providers have the right to advocate when acting within the lawful scope of their license and to advise or advocate for members on the following issues without restrictions or incrimination from ABHKY.
  - Health status, medical care, or treatment options (including sufficient information to enable the member to decide among various treatment options, and information regarding alternative treatments that may be self-administered)
  - Risks, benefits, and consequences of various treatment options
  - The opportunity to refuse treatment and/or express preferences for future treatment options
- Providers have the right to present a complaint, appeal, or grievance; the right to file appeals or complaints on your own behalf or on the behalf of your patient within 60 days of receipt of the denial or limited approval, with your patient's consent, without fear of retaliation, and to have those complaints resolved; the right to obtain a written decision at the end of the appeal process explaining why Aetna Better Health's prior decision is being upheld (if that is the case): the right to speak with the physician who, acting on behalf of Aetna Better Health, disapproves or limits approval of a request for covered services, and receive a written statement denying the approval upon request.
- Providers have the right to communicate openly with patients about all diagnostic testing and treatment options.
- Providers have the right to expect that their claims will be processed accurately, timely and by industry standards.
- Providers have the right to expect and receive respectful communication from knowledgeable staff and timely response to questions or concerns.
- The right to receive assistance with complex member issues.

## Cultural Competency

Aetna's approach to meet the linguistic and cultural needs of our members includes the development of a comprehensive cultural competency program. Cultural competency and health literacy are at the core of our service delivery. Aetna's Health Care Equity Director prepares a detailed Cultural Competency Plan (CCP) annually to ensure engagement of all health plan leaders and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards and to ensure compliance. The CCP outlines the processes used to develop and maintain a culturally competent staff and provider network. This comprehensive plan includes strategies designed to assist our staff, providers, and subcontractors with integrating cultural and linguistic competence and health literacy into every aspect of our organization. Our CCP focuses on effective and equitable care and services by respecting and honoring each enrollee's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background.

Cultural competency is part of the fabric of our organization, and it should infuse every aspect of member interaction and local, community-based care delivery. All of our contracted providers, including behavioral health, receive cultural competency training at orientation and on an ongoing basis, including the following:

- Cultural competency and impacts on health care
- Provider obligations for delivering culturally competent care
- Tools and resources such as Aunt Bertha, an online repository of community services

- Social determinants of health and trauma-informed care
- Training staff on the need to understand and respect cultural differences and develop services that better meet the needs of minority populations and remove barriers to care
- Assisting members with limited English proficiency
- Providing access to interpretive and American Sign Language services for Aetna enrollees

We realize that a critical element to providing quality service involves developing and maintaining culturally appropriate services that address diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the enrollee prevalent language(s) and sign language interpreters.

This diverse membership requires translation of written materials, telephonic, and face-to-face interpreter services. Aetna Better Health employs Spanish-speaking staff in the Member Services Department. Aetna Better Health provides telephonic interpretation services through our Language Line and will provide face-to-face interpretation services upon request. Aetna Better Health also uses the 711-relay service for members that use a TDD/TTY device for hearing and speech-impaired members.

The Aetna Better Health 24-Hour Nurse Line employs bilingual staff, supplemented as needed, by a third-party interpretation service vendor. The nurse line also supports members needing TDD/TTY services via a local TTY access number. Please refer to **important phone numbers** at the beginning of this manual.

### Translator and Interpreter Services

Aetna Better Health is committed to serving all our members. If you need assistance with translator or interpreter services, either from us or from your provider, we have programs in place to make sure you get the care you need. Please call us at **1-855-300-5528 (TTY: 711)**.

### Title VI of the Civil Rights Act of 1964

No person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination under any program or activity receiving federal assistance. The Title VI regulation prohibits retaliation for filing an unlawful discrimination complaint or for advocacy for a right protected by Title VI.

### Title VII of the Civil Rights Act of 1964

The Act prohibits discrimination based on race, color, national origin, sex, or religion in all employment activities (e.g., interviews, promotions, disciplinary actions, terminations, etc.).

### The Americans with Disabilities Act (ADA) of 1990 42 U.S.C. 12101 et seq (ADA)

The purpose of the Act is to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life. The Act also provides enforceable standards addressing discrimination against individuals with disabilities and ensures that the federal government plays a central role in enforcing these standards on behalf of individuals with disabilities.

Steps providers must take to comply:

- Designate a Civil Rights Coordinator or contact person for your facility.
- Publicly notify of a non-discrimination policy.
- Display a "Non-Discrimination in the Provision of Services" poster in a location easily accessible and visible to clients.
- Conduct civil rights training for employees.
- Develop a particular complaint procedure for clients wanting to file a complaint of discrimination.

Collect and maintain information regarding racial/ethnic make-up of workforce (if over 50 employees) and information on client or service complaints.

## Provider Training

Aetna Better Health of Kentucky (ABHKY) is committed to fostering a positive and collaborative experience for every provider serving our members. Our orientation and education programs are designed to deliver essential information in the most convenient and efficient manner possible, through a combination of virtual and in-person sessions, interactive webinars, and on-demand resources.

The primary goals of these programs are to:

- Support the delivery of high-quality, culturally appropriate, trauma informed focused care
- Ensure compliance with contractual and regulatory requirements
- Minimize disruption to providers' schedules

Providers receive ongoing updates via newsletters, bulletins, and virtual office hours. These cover topics such as prior authorization changes, coding updates, and documentation standards.

We actively seek feedback to develop new training topics and delivery methods. Our objective is to provide timely, relevant training that builds on prior education and addresses current needs. To achieve this, we continuously gather input on training materials for each audience.

**Behavioral Health Training:**

Aetna provides training to network primary care providers (PCPs) on:

- Screening and identification of behavioral health disorders
- Aetna's referral process for Behavioral Health Services
- Coordination requirements for behavioral health care
- Behavioral health screening techniques
- Emerging models of behavioral health interventions

For a complete list of training sessions, dates, and times—or to register—please scan the QR code provided or visit:

**https://AetnaBetterHealth.com/Kentucky/news-events.html**

## Network Notices & Bulletins

Aetna Better Health of Kentucky (ABHKY) is committed to open, transparent communication with our providers as we work together to develop innovative solutions that address Kentucky's unique healthcare needs.

**Policy and Program Updates:**

- Changes are communicated promptly through **Network Notices**, accompanied by additional training when necessary.
- Providers receive ongoing education and updates via our **quarterly newsletter**.
- **TIP Tuesday** delivers brief, routine updates and helpful information directly to providers.
- All policy and program changes are posted on our website and incorporated into this manual.

To sign up for **automatic notice distribution**, please scan the QR code provided or visit:

**https://lp.constantcontactpages.com/su/Y 4DwUms**

# Provider Tools & Resources

## Health Plan Website

The health plan website is a resource for members and providers.
Providers can use the website to access our:

- Provider manual
- Member Handbook
- Preferred Drug List (PDL)
- Clinical Guidelines
- Plan resources and frequently used documents
- Register for and access Availity
- Provider Directory
- Trainings & Events
- Network Notices & Newsletters

Visit the Website: For Health Care Providers | Aetna Medicaid Kentucky
(https://www.aetnabetterhealth.com/kentucky/providers/index.html)

## Provider Inquiries

Take advantage of our CONTACT US WEB FORM. This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need. As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department.

To access the form, visit https://www.aetnabetterhealth.com/kentucky/providers/index.html

Start by selecting **Contact Us** in the upper right corner. Next, fill out the reason for your inquiry. It will then ask you to share the appropriate contact from your practice and add essential information such as your Tax ID and NPI. You can also include up to 5 files with your inquiry if needed. Additionally, Aetna Better Health uses an Interactive Voice Response system (IVR) to allow providers to self-serve anytime. You can access the IVR by calling the Customer Service Department at **1-855-300- 5528.** You can speak with a customer service representative between the hours of 7 a.m. and 7 p.m. ET, Monday through Friday, including federal holidays. From the IVR, you can simply speak your responses to be routed to the correct area.

Caller Type – ***Press star (*) to indicate Provider***

- Claims – Press 1 –
    - Select the product:
        - Medical – Press 1
        - Pharmacy – Press 2
        - Dental – Press 3
        - Vision – Press 4

    - Select the action
        - Check Status – Press 1
        - Submit – Press 2
        - Something Else – Press 3

- Check on Appeal Status – Press 2 to transfer to the Appeal
- Eligibility/Benefits – Press 3
    - Medical – Press 1
    - Vision – Press 2
    - Mental – Press 3
    - Mental Health – Press 4
    - Something Else – Press 5
- Authorizations – Press 4
    - Submit One – Press 1
    - Concurrent Review – Press 2
    - Retro Review – Press 3
    - Peer-to-Peer Review – Press 4
    - Fax Authorization Request – Press 5
    - Something Else – Press 6
- More Options – Press 5
    - Report Fraud and Abuse – Press 1
    - Pharmacy Help Desk – Press 2
    - Care Manager – Press 3
    - Provider Services – Press 4
    - Something Else – Press 5

## Availity

The Availity Portal offers healthcare professionals free access to real-time information and instant responses in a consistent format regardless of the payer. Provider benefits include:

- Verify Member eligibility, covered services and view HEDIS needed services (care gaps)
- Add attachments to previously submitted claims
- Check Claims status
- Create and submit a Claim Appeal with attached files
- Create, submit, and check status of Prior Authorization/Service Requests
- Download forms and documents

## Changes in Provider and Demographic Information

Providers are required to provide a written notice of any changes in information concerning their practice to both Aetna Better Health of Kentucky Provider Network Management Department and DMS. Such changes include, but are not limited to:

- Physical address changes, including changes for satellite offices
- New enrollments/Terminations to your roster
- Changes in billing address, telephone numbers, and tax ID numbers
- Provider name changes

Changes may be reported by completing the "Provider Information Update/Change Form", which is located on the Aetna Better Health of Kentucky website, under Provider site, then Join Our Network. The form must be submitted via email to KyProviderUpdates@Aetna.com.

Reimbursement may be affected if changes are not reported in accordance with Aetna Better Health of Kentucky policy.

## Aetna Provider Partnership Program (AP3)

Aetna Better Health of Kentucky (ABHKY) has launched the Aetna Provider Partnership Program (AP3)-an initiative designed to strengthen provider relationships and reduce administrative burden. AP3 is built on three core elements: Councils, Concepts, and Campaigns.

- **Councils**: External and internal workgroups that collaborate to identify challenges and opportunities.
- **Concepts**: Ideas generated by these workgroups to improve processes and efficiency.
- **Campaigns**: Initiatives developed from these concepts to reduce administrative burden and enhance provider experience.

**Program Purpose:**

AP3 reviews, monitors, and evaluates ABHKY's policies, practices, and innovations with a focus on improving provider partnerships, reducing administrative complexity, and implementing operational efficiencies.

**Workgroup Structure**

AP3 consists of:

- **External Workgroups**: Comprised of provider representatives and office staff, these groups serve as a forum to identify administrative challenges and propose solutions.
- **Internal Workgroup**: Includes representatives from all health plan departments that interact with providers, ensuring alignment and follow-through on identified improvements.

**Provider Participation:**

Each workgroup identifies areas of administrative burden and recommends strategies for improvement. Providers selected to join AP3 commit to serving on a council for a minimum of **one year**.

- If you are interested in participating in any of the three councils, please contact your **Network Relations Manager** to request a selection form.

## Joining our Network

All practitioners must have an **active Kentucky Medicaid ID** to participate with Aetna Better Health of Kentucky (ABHKY).

For **New** Tax Identification Numbers (TINs):

- Complete a **contracting packet** before joining the network as a participating provider.
- The **Nomination Form** is available on the ABHKY website: https://www.aetnabetterhealth.com/kentucky
- Submit the completed Nomination Form via email to: KYProviderUpdates@aetna.com
- For questions regarding the Nomination Form, contact the **Network Relations team**.

**Contracting Requirements:**
During the contracting process, providers must submit:

- Enrollment Applications:
  - Practitioners: Complete a Practitioner Application or provide a Group Roster
  - Facilities: Complete a Facility Application
- Disclosure of Ownership Form
- W-9 Form
- Completed Contract Packet

## Credentialing/Re-Credentialing

Aetna Better Health is contracted with a certified Centralized Credentialing Verification Organization (CVO), Kentucky Health Alliance (KHA), and Verisys (formerly Aperture). KHA/Verisys is responsible for direct credentialing for our network of providers. Exception: Independent Physician Practice Associations (IPA) and hospital organizations that currently have a delegated credentialing agreement are excluded from this process.

New practitioners, including those joining an existing participating practice, must complete a Practitioner Application or supply an ABHKY approved group roster, and be approved by the credentialing committee. All enrollment requests should include a W-9 and be submitted to KyProviderUpdates@aetna.com.

The application and all credentialing forms can be found on the website at:
Join Our Provider Network | Aetna Medicaid Kentucky (AetnaBetterHealth.com)

**Credentialing Process and Application Requirement for Kentucky Medicaid**

For practitioners, Verisys accesses the Council for Affordable Quality Healthcare (CAQH) Provider Data Portal CAQH is a nonprofit alliance of America's leading health plans. CAQH allows practitioners to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort.

- Form KAPER-1/CAQH credentialing application shall be used when credentialing or re-credentialing health care professionals in a managed care plan. In addition to the Form KAPER 1/CAQH credentialing application, our applicant must provide the following information:
  - Copy of current valid license to practice
  - Copy of current DEA certification (if applicable)
  - Copy of educational degrees
  - Copy of board certificate (if applicable)
  - Copy of board certificate to serve children with special needs under 21 years of age (as applicable)
  - Copy of current malpractice coverage certificate
  - Copy of current BNDD certification (if applicable)
  - Copy of completed IRS W-9 form
  - Signed Attestation and Consent for Release of Information/Release from Liability form, including current date
  - Disclosure of Ownership form
  - Copy of physician collaborative practice agreement (if applicable)
  - Disclosure questions should be answered in full and additional information supplied, if necessary.

Upon receipt of the above requested information, Verisys will verify the provider's credentials and qualifications through primary sources. Primary sources may include, but are not limited to, the National Practitioner Data Bank (NPDB), licensing agencies, the Office of Inspector General (OIG), System Award Management (SAM f/k/a Excluded Parties List System (EPLS), American Board of Medical Specialties (ABMS)and AMA (American Medical Association).

**Re-Credentialing Requirements**

Aetna Better Health re-credentials each participating provider at least once every 36 months. Our providers are required to maintain the accuracy of their CAQH profile information for re-credentialing events. Verisys will outreach to the credentialing contact listed in the provider's CAQH profile should additional information be needed to complete the recredentialing event. Failure to provide the requested information could result in a credentialing denial and subsequently termination from our network.

Aetna Better Health maintains the confidentiality of all information obtained during the credentialing/re-credentialing process. All credentialing documents, or other written or electronic information collected, won't be disclosed to any person not directly involved in the credentialing process.

## Provider Selection Standards

Aetna Better Health uses the following provider selection standards to determine the selection of our primary and specialty care professionals:

- The provider's practice location is within the Kentucky Medicaid service area. A provider's practice may be located outside of the service area if the applicant's specialty meets the needs of the Aetna Better Health network.
- The provider is primarily engaged in providing services covered under the benefit contracts for which Aetna Better Health is providing or arranging such services.
- Providers must be enrolled in Kentucky Medicaid, must have an active Kentucky Medicaid ID number, and must maintain enrollment in Kentucky Medicaid.
- The provider holds a current professional license without material restrictions, conditions, or other disciplinary action taken against the applicant's license to practice.
- The provider maintains hospital privileges at an Aetna Better Health participating hospital, if applicant's practice requires hospital privileges.
- Provider holds a current and valid certification to prescribe opioid dependence treatment drugs and corresponding DEA registration number, if applicable.
- The highest level of education is verified to ensure the education for the participating specialty is verified. If the provider's board certification has been verified (except American Dental Association (ADA) board), no additional verification of education will be completed unless required by Kentucky statute. If a provider is not board certified, the highest level of medical education and the education for the participating specialty is verified. Verification occurs directly with the American Medical Association (AMA), American Optometric Association (AOA) Master Files, and the Royal College of Physicians and Surgeons of Canada (RCPSC), or directly with the primary source, as appropriate, as sources for education verification for physicians.
- Provider maintains adequate professional liability insurance coverage. At a minimum, the coverage must meet Commonwealth of Kentucky requirements.
- A provider's practice is not oriented toward clinically unsound, experimental, unproven, or otherwise inappropriate modalities of treatment.

- Aetna Better Health and our providers are partners in managing the health care of our members. Because of this mutual responsibility, we require our providers to adhere to the following standards:
    - Providers shall offer covered benefits and health care services to members consistent with Professionally recognized standards of health care.
    - Providers must render or order only medically appropriate services, supplies, and/or equipment.
    - Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws. Additionally, providers must maintain member records in an accurate and timely manner and according to the Medical Record Documentation Standards included in this Provider Manual.
    - Providers will not deny, limit, or condition the furnishing of covered health care services to members based on health factors including, but not limited to, mental or physical illness, claims experience, medical history, genetic information, and evidence of insurability or disability.
    - Providers shall cooperate with Aetna Better Health medical management activities and procedures to identify, assess, and establish a treatment plan for members with complex or serious medical conditions. This includes returning phone calls, answering correspondence, and responding to Aetna Better Health staff, as needed, so they can perform their medical management duties.
    - Providers must obtain authorizations for all hospitalizations and other services specified in this Provider Manual as requiring prior authorization.
    - Providers must agree to the terms of the Aetna Better Health provider participation agreement including all state and federal required provisions and maintain an acceptable professional image in the community.
    - Providers must keep their licenses and certifications current and in good standing and cooperate with the Aetna Better Health re-credentialing program. Aetna Better Health must be notified of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health.
    - Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/re-credentialing process. Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide at least 15 days' notice prior to the cancellation, loss, termination, or transfer of coverage.
    - Providers look solely to Aetna Better Health for payment of services furnished to members and must not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have claim or recourse against a member, or anyone acting on behalf of a member, under any circumstances unless explicitly approved for reason of coordination of benefits or subrogation. Applicable cost sharing can be collected at the time of service or billed to the member. Services cannot be denied to any member with cost sharing responsibilities if he/she cannot pay when the service is rendered. The member may be billed for the cost share amount.
    - Providers shall ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health, including medical records data required, and ensure the information is submitted on the appropriate claim form.
    - In the event the provider or Aetna Better Health seeks to terminate the participating provider agreement, it must be done in accordance with the contract.

- Providers must submit demographic or payment data changes at least 60 days prior to the effective date of change.
- Providers must be enrolled in Kentucky Medicaid, must have an active Kentucky Medicaid ID number, and must maintain enrollment in Kentucky Medicaid.
- Providers shall be available to Aetna Better Health members as outlined under "Scheduling Appointments and Waiting Times." Providers will arrange with other Aetna Better Health participating providers to deliver 24-hour on-call coverage for their members, as outlined within this Provider Manual. Please note the National Committee for Quality Assurance (NCQA) requires that access be no less for Medicaid recipients than it is for all other patient
- Providers shall ensure timely and confidential transfer of records between providers as outlined in Quality Management of this Provider Manual under "Transfer of Medical Records." Providers must become familiar, and to the extent necessary, comply with Aetna Better Health "Members Rights and Responsibilities" in Member Services and Benefits of this Provider Manual.
- Providers will ensure they honor all Aetna Better Health members' rights including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.
- By entering into the participating provider agreement, provider agrees to comply with all enumerated terms and conditions and abide by all applicable Aetna Better Health policies, procedures, and programs, as well as the Aetna Better Health Provider Manual. Further, the provider agrees to Aetna Better Health's ongoing monitoring of the provider to ensure compliance with the foregoing. The following is a representative list of the policies, procedures, and programs with which providers must comply. This list is not exhaustive and is subject to change upon appropriate notice to the affected providers.
    - Quality Improvement programs including, but not limited to, poly-pharmacy program, provider efficiency monitoring, data collection, and reporting programs, such as HEDIS® (Healthcare Effectiveness Data and Information Set)
    - "Never Event"/provider-preventable conditions policy
    - Fraud and Abuse/Program Integrity programs
    - Utilization management/review programs including, but not limited to, full cooperation with the appeals and grievances process as may be requested

- Participating providers agree to comply with the quality improvement, utilization review, peer review, grievance, credentialing and re-credentialing programs, and any other policies and procedures that Aetna Better Health may implement, including amendments made to the above-mentioned policies, procedures, and programs.
- In the event a provider fails to meet any of the participation requirements stated herein or does not agree to comply with such requirements going forward, Aetna Better Health reserves the right to refuse participation to a provider applicant. In addition, once providers are accepted into the network, they must continue to meet all such requirements or be subject to termination with cause in accordance with their participating provider agreement. In all cases where termination is proposed, Aetna Better Health will act in accordance with the timeframes and notice requirements stated in the applicable provider contract.

*Note: The poly-pharmacy program requires review of prescription practices including, but not limited to, members with a high number of unique drugs prescribed, drug duplication, interactions, and missing medications.*

Aetna Better Health encourages providers to contact their Network Relations Manager at any time if they require further details on requirements for participation.

## Provider Terminations

Providers may find they have to voluntarily terminate their participation with Aetna Better Health of Kentucky or that they be involuntarily removed for the reasons below.

### Provider Termination *with* Aetna Better Health of Kentucky

A provider desiring to terminate his/her participation with Aetna Better Health of Kentucky must submit a written termination notice to kyproviderupdates@aetna.com at least ninety (90) days prior to the desired effective date of the termination or in accordance with the provider agreement. For terminations of primary care providers, the health plan will coordinate member notification and assignment to another PCP based on the PCP's member panel. If a solo specialist or an entire specialty group decides to terminate the contract, a list of members receiving ongoing health care from the specialist and/or group must be sent to Aetna Better Health of Kentucky within sixty (60) days of the termination date for member notification to occur.

### Provider Termination *by* Aetna Better Health of Kentucky

Aetna Better Health may reduce, suspend, or terminate network participation privileges due to the following circumstances:

- Termination, revocation, or suspension of provider's license, certification, or accreditation in a final disciplinary action by a state licensing board or other governmental agency
- Provider's exclusion, suspension, or termination from participation in Medicare or Kentucky Medicaid
- Termination of provider's professional liability insurance
- Conviction of, or plea of no contest to, a felony or any criminal charge relating to health care delivery
- Aetna Better Health determines in good faith that the provider's performance is inadequate or that continued provision of services to members may result in, or is resulting in, danger to the health, safety, or welfare of members. Where the danger results from the actions of provider's staff, contractors, or subcontractors, then provider shall suspend its relationship with such staff, contractors, subcontractors upon immediate notice from Aetna Better Health, at least with respect to members. If a provider fails to take such action, Aetna Better Health may terminate the provider agreement upon ten (10) days' notice.

### Member Notification of Provider Terminations

Aetna Better Health will be solely responsible for notifying members that a provider or provider group is no longer a participating provider. Aetna Better Health will notify members at least thirty (30) calendar days prior to the effective date of the termination, or upon becoming aware of the termination, and will help them select a new practitioner.

### Continuation of Care after Termination

Unless a provider is terminated from Aetna Better Health's network due to fraud or quality of care issues, the provider shall continue to treat members who are receiving treatment at the time of termination or who are hospitalized on the date the participating provider agreement terminates or expires until the course of treatment is completed or through the date of each such member's discharge from an inpatient facility,

whichever is longer. In the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is at least twelve (12) weeks and one (1) day pregnant at the time of termination. Continuation of services shall be made in accordance with the terms and conditions of the provider's participation agreement with Aetna Better Health as it may be amended and in effect at the time including, but not limited to, the compensation rates and terms set forth therein. Provision for the continuation of care shall guarantee that the member is not liable to the terminating provider for any amounts owed for medical care.

## Other Provider Concerns

- **Out of Network Providers -** When a member with a special need or service cannot be serviced through a contracted provider, Aetna Better Health of Kentucky may authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider when a network provider is unavailable. If needed, our Contracting Department will negotiate a Single Case Agreement (SCA) for the service and evaluate the potential for recruitment to join the provider network. The member may be transitioned to a network provider (once identified) when the treatment or service has been completed, or the member's condition is stable enough to allow for transfer of care. Providers must have a KY Medicaid ID number to negotiate a SCA.
- **Communication with Providers -** Aetna Better Health does not prohibit providers from giving members information regarding treatment options, or from discussing with members how their benefit coverage relates to their medical needs. Providers are not prohibited from advocating on behalf of members or informing the members of their right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

- **Medicaid Provider Preventable Condition Claim Denial and Reporting Process -** Aetna Better Health's participating providers agree to abide by the Aetna Better Health policy on "Medicaid Provider Preventable Condition (PPC) Claim Denial and Reporting Process," which is compliant with applicable state and federal law. The PPC Policy shall be provided upon written request and may be updated from time to time by Aetna Better Health. Reimbursement for care associated with PPC shall be determined solely in accordance with the Aetna Better Health PPC Policy. All providers should report PPCs to Aetna Better Health of Kentucky.

## Telehealth Services

Telehealth can be used as an alternative to or to complement traditional service delivery. In alignment with Commonwealth regulations, specific available services include consultation, mental health evaluation and management, individual and group psychotherapy; pharmacologic management, psychiatric/psychological/mental health diagnostic interview examinations, and individual medical nutrition therapy consultation services. In-network providers may use their own approved technology or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their enrollees via telehealth. Alternatively, if indicated, preferred Kentucky-licensed subcontractor's telehealth practitioners will be utilized, as per Kentucky regulations, to meet both the physical and behavioral health needs of our enrollees using evidence-based protocols. Unless otherwise agreed upon or directed by the Department, provider reimbursement for telehealth services will be equivalent to that given for the same in-person services.

Telehealth alternatives make ongoing care and follow-ups more convenient and easier to schedule. Members can more easily schedule recurring appointments at preferred times. In addition, the use of mobile devices and applications make telehealth and remote patient monitoring (RPM) devices and applications more acceptable to a growing number of individuals who are already comfortable with the technology. Telehealth services and RPM allow members to seek treatment from the comfort of their own surroundings—reducing stigma and increasing the chances they will seek treatment.

### Kentucky Health Information Exchange - KHIE

The KHIE is a secure, interoperable network in which participating providers with certified electronic health records technology (CEHRT) can share needed patient health information and other providers' access at the point of care. As part of our commitment, we are working with the newly designed KHIE platform to develop a transformative solution to optimize care coordination and service delivery and to achieve quality outcomes.

Providers who contract with us must sign a participation agreement with KHIE. This will also help providers fulfill meaningful use requirements to qualify for Medicaid's EHR (Electronic Health Records) Incentive Payment Program since providers must have a signed participation agreement and signed addendums on file with KHIE for each public health objective selected for attestation.

Intended for all facilities, Aetna Better Health also recommends the submission of ADTs (Admission, Discharge, Transfer messages) to KHIE.

For providers who do not have electronic health records, Aetna Better Health recommends those offices to sign a Participation Agreement with KHIE. Aetna Better Health also recommends signing up for Direct Secure Messaging services so that the clinical information can be shared securely with other providers in their community of care.

For additional information on KHIE, please visit https://khie.ky.gov/Pages/index.aspx

To begin participating with KHIE, please contact your regional Outreach Coordinator by visiting the website at http://khie.ky.gov and learn how to make the KHIE Connection.

## Medical Services

Aetna Better Health has a network of contracted providers, including hospitals, ancillaries, physicians, and advanced practice nurses, available to cover all medically necessary services required by members. Please refer to the Provider Search option on the Aetna Better Health website at For Health Care Providers | Aetna Medicaid Kentucky for a complete listing of network providers for a complete listing of network providers.

## Member Identification (ID) Card

Aetna Better Health member ID card should be reviewed prior to rendering services. Any questions regarding benefit coverage should be directed to Aetna Better Health Member Services at **1-855-300-5528**.

Members are always encouraged to carry their Aetna Better Health Member ID card. Should a member be present without a Member ID card, the provider should verify their identity by reviewing a valid Commonwealth of Kentucky driver's license or Kentucky-issued ID card; if valid, services should not be denied. Payment for services is subject to member eligibility at the time of services. The provider is required to verify the member's eligibility and applicable cost-sharing through either:

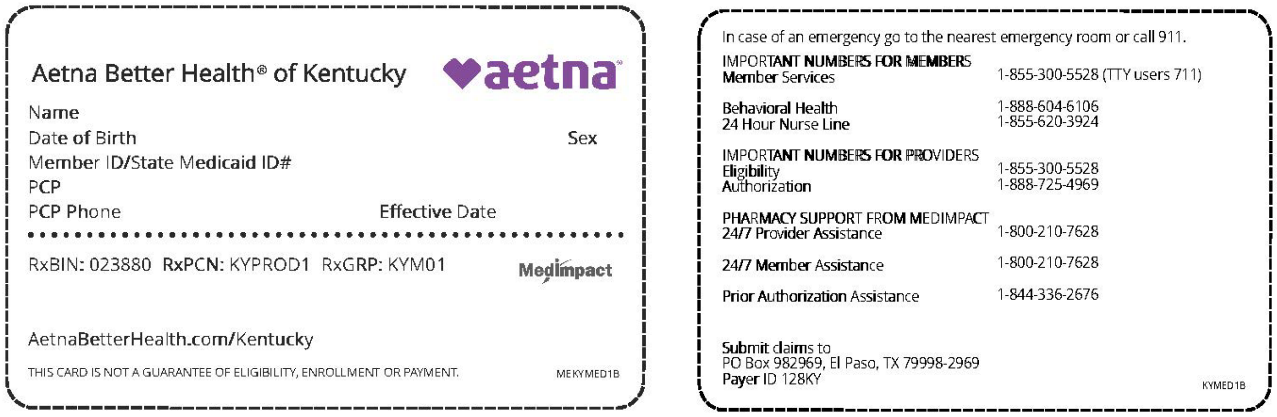
- KYHealth-Net
- Aetna Better Health of Kentucky Member Services at **1-855-300-5528**
- Availity - https://apps.availity.com/availity/web/public.elegant.login

A provider must also verify if a member has been enrolled in the Supportive Managed Care Program which directs members to certain providers. Failure to verify a member's enrollment in the Supportive Managed Care Program will result in claims denials for providers who are not on the member's restricted provider list.

To verify a member's enrollment in the Supportive Managed Care Program, call Aetna Better Health Member Services at

**1-855-300-5528**.

**Sample Member ID Card**




## Member Services Department

Our Aetna Better Health Member Services Department is available Monday–Friday, 7 AM to 7 PM ET at **1-855-300-5528**. Please have your National Provider Identifier (NPI), Aetna Better Health Provider ID number, or tax ID available for HIPAA verification purposes.

We will be closed on these federal holidays:

- New Year's Day
- Dr. Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

## Behavioral Health Services Hotline

Aetna Better Health has a toll-free emergency and crisis Behavioral Health Services Hotline that is staffed by trained personnel 24 hours a day, 7 days a week, 365 days a year, **1-888-604-6106.** Qualified behavioral health service professionals are available to access, triage, and address behavioral health emergencies and can arrange emergency and crisis behavioral health services via mobile crisis teams. Face-to-face emergency services are available 24 hours a day, 7 days a week. The Behavioral Health Services Hotline is not answered by any automated means, and incoming calls will not receive a busy signal.

## Member Secure Portal

At AetnaBetterHealth.com/Kentucky**,** members can register for their own secure member portal accounts. However, we've customized the member portal to better meet their needs. Members will have access to:

- **Health and Wellness Appraisal** – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members' overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- **Educational resources and programs** – Members can access self-management tools for specific topics, such as smoking cessation and weight management.
- **Claim status** – Members can follow a claim from the beginning to the end, including current stage in the process, amount approved, amount paid, member cost (if applicable), and the date paid.
- **Personalized health plan services information** – Members can now request a member ID card, change PCPs, and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain information regarding referrals and authorization requirements. In addition, they can find benefit and financial responsibility information for a specific service.
- **Innovative services information** – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- **Health Information Line** – The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- **Wellness and prevention information** – We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self-management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at AetnaBetterHealth.com/Kentucky or call Member Services at **1-855-300-5528**.

## Members' Rights and Responsibilities

Aetna Better Health of Kentucky members, both adults and children, have specific rights and responsibilities. These are also included in the Member Handbook.

**Member Rights:**
As a member you have the right to:

- Get good medical care regardless of race, color, religion, sex, age, disability, sexual orientation, gender identity, or nationality
- Be treated with respect and dignity and have your privacy protected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

- Have a choice about your Aetna Better Health PCP and be able to change your PCP within the rules
- Get medical care when you need it
- Ask questions and get complete information about your medical condition and treatment options, including specialty care, regardless of cost or benefit coverage
- Be told that services are not covered before you get them
- Be part of all decisions about your health care, including the right to refuse treatment
- Ask for a second opinion
- Have your medical records and care kept private
- Look at copies of your medical records, get copies if you want them, and get assistance with them in accordance with applicable federal and state laws
- File a complaint or an appeal with Aetna Better Health or ask for a State Fair Hearing from the Department for Medicaid Services, if you have problems with your eligibility or health care
- Get help with filing a complaint or appeal
- Have timely access to care including specialty care
- Make sure communication or physical barriers do not limit timely access to care
- Get information in a way that is easy to understand
- Get free translation services, if needed
- To be free to exercise your rights without anyone treating you adversely
- Prepare Advance Medical Directives according to Kentucky laws
- Ask for a description of payment methods Aetna Better Health uses to pay providers for member care
- Be told at least thirty (30) days before any program or site changes that affect you
- Make recommendations regarding the health plan's Member Rights and Responsibilities Policy
- Receive information about our organization, our services, our practitioners and providers, and member rights and responsibilities
- Request an overview of the Medicaid program and a list of benefits outlined in the Member Handbook once a year. Any change in the information listed will be communicated at least thirty (30) days before the change is made.
- Any Native American enrolled with Aetna Better Health is eligible to receive services from an Aetna Better Health network participating I/T/U provider or an I/T/U primary care provider. I/T/U are the Indian Health Service, Tribes and Tribal organizations, and Urban Indian Organizations (collectively referred to as "I/T/U").

**Member Responsibility:**
Members have a responsibility to:

- Give the best information you can so that Aetna Better Health providers can take care of you and your family
- Follow your PCP's instructions and care plans
- Actively participate in personal health and care decisions and practice healthy lifestyles
- Call your PCP first when you need medical care. In an emergency, you should call 911 or go to the closest emergency room
- Go to providers who take your Aetna Better Health Member ID card
- Show your Aetna Better Health Member ID card every time you get medical services
- Show your other insurance card if you have other health insurance coverage
- Make sure that you only see Aetna Better Health providers
- Keep all appointments and be on time
- Cancel an appointment if you cannot get there
- Follow Aetna Better Health and Kentucky Medicaid policies and procedures
- Follow the rules of your PCP's office or clinic (if you or others do not follow the rules, your provider can ask you to leave)
- Ask your PCP questions if you do not understand something about your medical care
- Tell the truth about yourself and your medical problems
- Report suspected fraud and abuse
- Tell the Department for Community Based Services (DCBS) or Social Security Administration (SSA) about changes to your name, address, and telephone number
- Notify DCBS or SSA if you have a change, such as a birth, death, marriage, or obtain other insurance
- Learn the difference between an emergency and urgent care
- Understand your rights and responsibilities as a Kentucky Medicaid member

## Member Incentives

Aetna Better Health is offering a member incentive program to encourage consistent improvements in health outcomes for our members. Details can be found in the Appendix.

## Member Portal

Our Health Innovation Platform is a tool that will allow our members, care managers, and member services staff to easily view and engage with the value-added benefits (VAB) for which they are eligible. This tool will improve our ability to track and monitor eligibility, engagement, effectiveness, spend, and utilization trends for all VAB. The platform will also enable member engagement with and management of their VAB through the Medicaid Member Application and the member portal.

The platform streamlines all oversight functions, including the following:

- Addressing health disparities by proactively monitoring underutilization trends among key at-risk populations
- Preventing fraud, waste, and abuse through benefit design management
- Identifying opportunities to better promote and improve our value-added services to meet the needs of our enrollees
- Measuring benefit impact through enrollee satisfaction and, where applicable, health outcomes

## Member Selection of a PCP

For some members, selecting a PCP can be an overwhelming experience, as there are many factors to consider, such as gender, language, and location. In addition, some members may not understand why they must choose a PCP. A PCP understands a member's medical history, family medical history, and personal habits. PCPs can also tailor solutions that are specific to a member's health. Aetna provides up-to- date information to help members make an informed choice based on their needs by offering a wide variety of PCPs who are located throughout the Commonwealth, including federally qualified health centers (FQHCs), rural health centers, individual practitioners, and large group providers that offer multiple service locations.

Members are given the opportunity to select primary care providers (PCPs) when they enroll in the Medicaid Managed Care program. Members may select a specialty provider to serve as PCP under certain circumstances depending on the member's needs including for a member who has a gynecological or obstetrical heath care need, disability, or chronic illness. These requests will be reviewed by the Aetna Better Health Medical Director to ensure the requested specialist agrees to accept the role of PCP and assume all the responsibilities associated with this role. If a member does NOT select a PCP within thirty (30) days from enrollment, Aetna Better Health assigns one. Aetna Better Health shall consider factors such as language, location, and special needs.

The member may request a PCP change if the provider was automatically assigned by Aetna Better Health upon notification of the PCP assignment. A list of PCPs is made available to all members. Member Services representatives are available to assist members with PCP selection. Members are given the freedom to select participating PCPs based on age limit restrictions. Members are encouraged to choose a PCP that is geographically convenient but is not restricted by any geographic locations.

## Procedure for Members to Change PCP

Members may change their PCP, when eligible, by contacting Member Services at **1-855-300-5528**, or by using our secured member web portal or mobile application. A member has the right to change the PCP ninety (90) days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by Aetna Better Health.

Members (except members enrolled in the Supportive Managed Care Program) shall have the right to change PCPs at any time for any reason as approved by Aetna Better Health. Members may also change PCPs due to a temporary loss of eligibility and when this loss caused the member to miss the annual opportunity to change PCPs. Members may also change PCPs if Medicaid or Medicare imposes sanctions on their PCP, or if the member and/or the PCP are no longer located in the service area.

Members shall also have the right to change PCPs at any time for cause. Cause includes denied access to needed medical services, poor quality of care, and no access to providers qualified to treat his/her health care needs. If Aetna Better Health approves the request, the assignment will occur no later than the first day of the second month following the month of the request.

Members also have the right to request a PCP change through the member grievance process. When the PCP change is ordered as part of a resolution to a formal grievance proceeding, the change shall not be restricted.

PCP change requests made between the first and fifteenth of the current month are effective on the first day of the month. PCP change requests made after the 15th of the current month are effective on the first day of the following month. Exceptions may be made by Member Services on a case-by-case basis and if there is an urgent need for a member to make an appointment. Children in Commonwealth of Kentucky custody or foster care placement can make PCP changes at will.

## Member Disenrollment from PCP

A PCP may request removal of a member from his/her panel when supporting documentation is presented.

PCPs shall have the right to request a member's disenrollment from his/her practice and be reassigned to a new PCP in the event of incompatibility of the PCP/member relationship or the PCP's inability to meet the medical needs of the member.

PCPs shall have the right to request an enrollee's disenrollment from his/her practice and to be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship, enrollee has not utilized a service within one (1) year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year, or inability to meet the medical needs of the enrollee.

PCPs shall not have the right to request a member's disenrollment from their practice for the following reasons:

- Change in the member's health status or need for treatment
- Member's utilization of medical services
- Member's diminished mental capacity
- Disruptive behavior that results from the member's special health care needs unless the behavior

impairs the ability of the PCP to furnish services to the member or others

Transfer requests shall not be based on race, color, national origin, handicap, age, gender, sexual orientation, or gender identity. The initial provider must serve the member until the new provider begins serving the member, barring ethical or legal issues.

The PCP must submit the request in writing along with supporting documentation to Aetna Better Health Network Relations Department for review and reassignment. The request must include member identification, reason for transfer, PCP information, and signature. Mail to:

Aetna Better Health of Kentucky
Attn: Network Relations Department
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

Upon receipt of the request, the Network Relations team will acknowledge the provider indicating that they must continue to provide services to the member for a minimum of thirty (30) days or until the member is assigned to a new provider.

An outreach effort will be made from Aetna Better Health to the member to inform him or her of the provider's request to release them as a member. Aetna Better Health will work with the members to identify and attempt to remove any barriers between the member and provider. If outreach does not resolve the issue, a Customer Service Representative will assist the member with choosing a new PCP.

If Aetna Better Health cannot successfully reach the member after three (3) documented attempts within a two-week period, the Customer Service Representative will send a request to Network Relations requesting the PCP auto assignment change for the member. The PCP change request will be sent to Member Services for processing.

Once the PCP change is made, the Enrollment Department will mail a letter to the member explaining the reason for the PCP change and to tell them a new Aetna Better Health member ID card will be sent to them with the new PCP information within 7 to 10 business days. The member may call Member Services at **1-855-300-5528** during normal business hours to change the assigned PCP.

## Member Disenrollment from Aetna Better Health of Kentucky

The Cabinet for Health and Family Services has sole authority to disenroll members and may disenroll members for any of the following reasons:

- By member selecting another managed care organization (MCO) during open enrollment
- By member selecting another managed care organization within the first ninety (90) days following initial enrollment with an MCO
- To implement the decision of a grievance proceeding by the member against Aetna Better Health
- By request of Aetna Better Health if the member:
    - Is found guilty of fraud in a court of law or administratively
    - Determined to have committed fraud related to the Medicaid program
    - Is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers to either the Contractor, Contractor's agents, or providers
    - No longer resides in the Aetna Better Health service area
    - Is admitted to a nursing facility for more than thirty-one (31) days
    - Is incarcerated in a correctional facility
    - Is no longer eligible for the Medicaid Managed Care Program

## Member Copayments

Amendment KRS 205.6312 prohibits the Cabinet, or a Managed Care Organization contracted to provide services from instituting copayments, cost sharing, or similar charges to be paid by any medical assistance recipients, their spouses, or parents. There are no copayments for Aetna Better Health members.

## Benefit Determinations

Aetna Better Health has established benefit plans for its members. Please refer to AetnaBetterHealth.com/Kentucky for the most current version of the applicable benefits plans. For specific questions or for clarification of covered benefits, contact the Aetna Better Health Member Services Department at **1-855-300-5528**.

## Covered Services

- Acute Inpatient Hospital Services: Inpatient Physician/Surgeon Services, Transplant, Emergency Room (ER), Emergency Ambulance (ground or air,) Outpatient Hospital
- Ambulatory Surgical Center
- Rural Health Clinic (RHC),
- Federally Qualified Health Center (FQHC) & Primary Care Center (PCC)
- Dental Services (adults)
- Home Health Care
- Vision Services (adults), Vision Services (children)
- Urgent Care
- Radiation Therapy
- Chemotherapy

- Family Planning Podiatry
- Prenatal and Postnatal Care
- Skilled Nursing and Rehabilitation
- Chiropractic Services
- Durable Medical Equipment
- Hearing Aids/Audiometric Services
- Orthotic/Prosthetic Devices
- Physical/Occupational/Speech Therapy
- Private Duty Nursing
- Laboratory, Diagnostic, and Radiology Services(outpatient)
- Autism Spectrum Disorders
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services
- Commission for Children with Special Health Care Needs
- Specialized Children's Services Clinics
- Targeted Case Management: Severe emotional disability (SED) Children
- First Steps Services
- Targeted Case Management
- Inpatient Mental Health/Substance Use Services
- Outpatient Mental Health/ Substance Use Services
- Psychiatric Residential Treatment Facilities (PRTFs)
- Smoking/Tobacco Cessation
- Allergy Services
- Wellness services (immunizations and other preventative health services, such as, check-ups, pap smears, blook pressure screenings)

## Member Appeals and Grievances

A member appeal is a formal request from a member to review an action taken by ABHKY. An appeal may also be filed on the member's behalf by an authorized representative or a provider with the member's written consent.

## Member Complaints

Members have two (2) processes to indicate dissatisfaction. Members may file an appeal or a complaint. If a member or the member's representative asks, we can expedite the processing time of the appeal.

We will grant the request to speed up the appeal if the normal 30-day timeframe could seriously harm the member's life or health or ability to attain, maintain, or regain maximum function. The grievance process does not have an option to request expedited processing.

For both standard and expedited appeals, members have the right to submit written comments or documentation. If a case is about a clinical decision, members also have the right to request and receive a written copy of the Utilization Management criteria.

| Process Definitions | | |
|---|---|---|
| **Process** | **Definition** | **Determination timeframes** |
| Grievance (complaint) | A member's complaint is any expression of dissatisfaction with us or the way we operate. Concerns about actions we took based on our contract with CHFS aren't included in this definition. | Member grievance will be resolved within 30 calendar days. |
| Appeal | A member appeal is a request for a review of any matter about an action which is defined as a denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part of payment for a service; or our failure to act within acceptable timeframes for prior authorization review process. If we determine the request for an expedited appeal does not meet the Commonwealth's definition of an expedited appeal, we will process the appeal in the standard appeal period. We will make reasonable effort to contact the member by phone promptly if we cannot process the appeal as an expedited appeal. We will also send a letter to the member, letting them know we will process the appeal as a standard appeal. If the member files an appeal by phone, they must also send us an appeal letter in writing to complete the appeal request. Without the appeal letter, we are unable to open the case. | Member appeal will be resolved within 30 calendar days; such timeframe may be extended with the member's consent or at the member's request, when in the member's best interest, by no more than 14 calendar days. |

We will acknowledge receipt of the grievance in writing within five (5) days. We will send a copy of the letter to the member and to their representative if there is one. We may ask for supporting documentation so we can investigate the members' concerns as thoroughly as possible. When we finish reviewing the member complaint, we will send a letter explaining the resolution. A copy of the letter will be sent to the members and any representative they have designated. The member and their representative both have the right to ask for a copy of whatever criteria or standards we use to decide on the complaint. If you are unhappy about the outcome, you can request an appeal of the final complaint decision. You are not obligated to file a complaint before you file an appeal. Members have the right to file a complaint about an appeal decision if they are unhappy with the result.

Providers acting on behalf of a member, with consent, have the same opportunity. In some cases, we may extend the complaint response time by fourteen (14) days if it is beneficial to you. If this is not acceptable to you, you have the right to file a grievance to dispute the extra days.

On request, we assist members who want to file a complaint or an appeal. We also have a toll-free number **1-855-300-5528**, a relay number **(711)**, and interpretive services.

Any member may ask that we continue their benefits during the appeal process or during a State Fair Hearing. The Member Handbook and our denial letters explain these rights. Members can request that we continue their benefits if:

- They write or call us to request an extension of benefits
- They have filed an appeal about a service we discontinued (permanently or temporarily) or a service that was authorized before but has been reduced in amount
- An authorized provider ordered the service
- The authorization period has not expired for the service

If the State Fair Hearing reviewer agrees with our decision, the member may have to pay for the cost of any disputed services we provided while the appeal was in process. No punitive action or retaliation will be taken towards a member or provider in response to an appeal or a complaint. Also, we will never discriminate against a member or provider for filing a complaint or appeal.

### Provider Filing on Behalf of Member

A provider has the right to act on behalf of the member and file a member complaint. To act for a member, the member must give you written permission, or consent, to be their authorized representative. The state guideline says this written permission must be specific to the issue at hand and cannot be a generic assignment of rights or consent form. If you call us, we can send you a consent form. Once the member signs the form, you can fax it or mail it to us.

### Facility Site Review

A facility site review will be conducted in response to member complaints, for quality reviews, or for unaccredited ancillary/facility providers. The site review includes, but is not limited to, the following areas:

- Physical access
- Physical appearance
- Office hours
- Adequacy of waiting and examining areas
- Availability of appointments
- Emergency and safety
- Adequacy of equipment
- Emergency medication

### Medical Record Review

Providers who do not have an acceptable facility site review may be required to provide a corrective action plan.

## Member Appeals

A member may file an appeal: a formal request to reconsider a decision, such as a utilization review recommendation or administrative action. Per Kentucky law, with the member's written permission, a provider may file an appeal for a member. The state guideline says this written permission must be specific to the issue on appeal and cannot be a generic assignment of rights or consent form. Member appeals must:

- Be filed within thirty (30) days of the last notice of action.
- Include written authorization from the member that:
    - Specifically says you (as their provider) can file an appeal for the member.
    - Specifically notes what you are appealing.

We will let the members, and their representatives know we received the appeal within five (5) business days after we receive the appeal. We will decide on the appeal and send a letter to the members and their representative within thirty (30) calendar days of the date the appeal was received. In some cases, we may extend the appeal response time by fourteen (14) days if it is beneficial to the member. If the extra time we use for investigating the appeal is not acceptable to either the member or the representative, you both have the right to file a grievance to dispute the extra days.

A written copy of the criteria, policy, or procedure we used to make the appeal decision can be requested at any time if the case was about a clinical decision. No punitive action or retaliation will be taken towards a member or provider in response to an appeal or a complaint. Also, we will never discriminate against a member or provider for filing a complaint or appeal.

## Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that may be contrary to the provider's conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact a Network Manager. A Network Manager will work with the provider to review the member's needs and transfer or refer the member to another appropriately qualified provider for care.

## Access to Records

All records, books, and papers of provider pertaining to members, including without limitation, records, books, and papers relating to professional and ancillary care provided to members and financial, accounting, and administrative records, books, and papers, shall be open for inspection and copying by Aetna Better Health, its designee, and/or authorized state or federal authorities during provider's normal business hours. The provider further agrees that it shall release a member's medical records to Aetna Better Health or to other entities as otherwise required by law. In addition, providers shall allow Aetna Better Health to audit provider's records for payment and claims review purposes. Aetna Better Health agrees to provide at least a 48-hour notice prior to requesting access under this subsection.

# Access/Availability Standards

## Availability Standards

To ensure timely, high-quality care for our members, all participating providers must adhere to the following access and availability standards. These standards are designed to promote member safety, improve health outcomes, and maintain compliance with state and federal requirements. Providers are expected to meet or exceed these standards for appointment scheduling, after-hours access, and emergency care.

| Provider type | Appointment type | Availability |
|---|---|---|
| PCP | Routine Care | Within 30 Days |
| | Urgent Care | Within 48 Hours |
| | Non-Urgent | Within 72 Hours |
| | Return After-Hours Calls | Within 30 Minutes |
| | Emergency Care | Same Day |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |
| Pediatrics | Urgent Care | Within 48 Hours |
| | Sick Care | Within 30 Days |
| | Return After-Hours Calls | Within 30 Minutes |
| | Emergency Care | Same Day |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |
| Specialist | Routine Care | Within 30 Days |
| | Urgent Care | Within 48 Hours |
| | Return After-Hours Calls | Within 30 Minutes |
| | Emergency Care | Same Day |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |
| Oncology | Next Available Appointment | Within 30 Days |
| | Urgent Care | Within 48 Hours |
| | Return After-Hours Calls | Within 30 Minutes |
| | Emergency Care | Same Day |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |
| OBGYN | Routine or Next Available Appointment | Within 30 Days |
| | Urgent Care | Within 48 Hours |
| | Initial Prenatal Visit for Pregnant Women in First Trimester | Within 14 Days |
| | Initial Prenatal Visit for Pregnant Women in Second Trimester | Within 7 Days |
| | Initial Prenatal Visit for Pregnant Women in Third Trimester | Within 3 Days |
| | Initial Prenatal Visit for Pregnant Women with High-Risk Pregnancies | Within 3 Days |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |

| | | |
|---|---|---|
| Behavioral Health | Urgent Care | Within 48 Hours |
| | Non-Life-Threatening Psychiatric Emergency | Within 6 Hours |
| | Inpatient Follow-Up | Within 7 Days |
| | Initial Routine Care | Within 10 Business Days |
| | Routine Care Follow-Up | Within 30 Days |
| | Missed Inpatient Appointment Follow-Up | Within 24 Hours |
| | After-Hours Care (answering service; on-call MDs) | 24 hours a day; 7 days a week |
| All | Waiting room time | 45 Minutes* |
| General Dentist Services | Regular | Within 3 Weeks |
| | Urgent Care | Within 48 Hours |
| General Vision, Lab, and X-ray Services | Regular | Within 30 Days |
| | Urgent Care | Within 48 Hours |

**Does not apply to Emergency Room wait times*

## Missed Appointments/Follow-up Visits

Providers should contact members regarding missed appointments. The following guidelines should be used to track compliance and to assist members with keeping scheduled appointments:

- Contact phone numbers should be requested and confirmed with the member at each appointment.
- If the member fails to keep his/her scheduled appointment, the provider office staff should document the occurrence in the member's medical record.
- The office staff may contact Aetna Better Health Member Services Department at **1-855-300-5528** for assistance when members cannot be reached by telephone to verify appointments.
- Providers should encourage member compliance to minimize no-shows. Provider offices may provide a return appointment card for each member and are encouraged to make a reminder call one (1) day before a scheduled appointment.
- Providers may not bill or collect fees from members for missed appointments.
- Providers may request that Aetna Better Health Member Services Department call members to educate about chronic missed appointments.

KYHealthNet now has a panel for entering missed and cancelled appointments. The Commonwealth recognizes that a member missing an appointment or canceling with little notice is a loss of revenue for your organization and prevents another member quicker access to services.

Please take a few seconds to provide us with information about missed or canceled appointments so we can act to reduce those cases through outreach and, if appropriate, care management. On the new system

panel, enter information when a Medicaid patient misses or cancels a scheduled appointment(s). You will find a User Guide and video that may answer any questions you have about entering information on this new panel posted on the Commonwealth's website at www.chfs.ky.gov.

For additional information regarding transportation benefits, please reference transportation services under Member Services and Benefits.

## Twenty-Four (24) Hour Access to Care

Providers must ensure that members have access to care **24 hours a day, 7 days a week**. This includes arranging and maintaining **after-hours on-call coverage** with participating providers to support continuity and quality of care.

**Compliance Monitoring:**

- **Network Relations** conducts random after-hours surveys to verify compliance with access standards.
- Providers who fail to meet after-hours access requirements will be contacted for corrective action.
- Continued non-compliance may result in **formal corrective measures** as outlined in the provider agreement.

## Management of After-Hours Access to Services

- **Provider after-hours on-call services**: As stated above, providers are required to provide and maintain after-hours on-call coverage with participating providers 24 hours a day, 7 days a week. Calls must be returned to a member within a maximum of thirty (30) minutes.
- **Aetna Better Health 24-hour nurse line**: **1-855-620-3924** - The Aetna Better Health 24-hour nurse line is available to all members to assist with questions regarding medical concerns. The 24-hour nurse line will assist members in obtaining emergency services.

## Authorizations of After-Hours Services

Providers must request authorization of after-hours services by the end of the next business day.

- **Covering providers**

  Providers may use a back-up provider for on-call coverage to provide services 24 hours a day, 7 days a week. The coordination of on-call coverage is the sole responsibility of the arranging provider. Providers should use other Aetna Better Health participating providers for back-up coverage arrangements and ensure they are knowledgeable or have access to and will comply with Aetna Better Health policies and requirements. The provider remains ultimately responsible for the member's care.
- **Phone line transfer**

  The provider's phone line is transferred directly to the provider's designated after-hours number (i.e., mobile number or answering service). Aetna Better Health's participating providers are expected to respond to after-hours calls within thirty (30) minutes of call received.

## Member to Practitioner Ratio: PCP Capacity Monitoring

Per contract guidelines, Aetna Better Health has established the following member-to-primary care provider standards to measure provider capacity for its provider network and ensure adequate network capacity of primary care providers by region.

| Provider type | Member to PCP capacity standards |
|---|---|
| Primary Care Providers | 1500:1 = 1500 members to 1 practitioner |

## PCP Panel Limit

Aetna Better Health reserves the right to limit the panel size of individual primary care providers to provide adequate access and availability for services. For group practices, the panel size limit will be adjusted in accordance with the number of available providers. Any decision by Aetna Better Health to limit the panel size due to access or availability concerns will be communicated in writing to the provider.

## Panel Closings

Please note that if you close your panel to Aetna Better Health members, you must close your panel to all payers/members. All requests to close your panel must be submitted in writing to your Network Relations Manager with at least sixty (60) days' advance notice.

## Subcontracting Services

Providers shall not subcontract any services required to be provided under their agreement, or any portion of their agreement, without prior written consent of Aetna Better Health if the subcontract requires a member to receive covered services at locations other than provider locations.

## Continuity of Care

Providers are required to arrange and maintain covered services for new members who are transitioning from fee-for-service prior to enrolling with Aetna Better Health. This involvement ensures the overall quality and continuity of care for the members.

## Medical Record Documentation

Our providers shall maintain, at a minimum, a primary medical record for each member that includes:

- Member name/member identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, email address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no telephone number exists, then provide contact name and number of emergency contacts), consent forms, language spoken, and guardianship information
- Legible record to someone other than the author. Any record judged illegible by one reviewer shall be evaluated by another reviewer.
- All entries and encounters dated (month, day, and year) for the date of data entry and date of encounter.

- Provider identification by name of author and credentials (MD, DO, RN, MA, etc.).
- Medication allergies, adverse reactions, and any known allergies shall be noted in a prominent location and kept up to date.
- Past medical history and including, but not limited to, serious accidents, operations, illnesses, prenatal/obstetrical history; for children: past medical history includes prenatal care and birth information, operations, and childhood illnesses (e.g., documentation of chickenpox)
- History and physical with appropriate documented subjective (chief complaints or purpose of visit) findings and should include the history of current illness. Appropriate objective findings (physical exam) are documented and related to complaints or purpose of visit.
- A diagnosis, working diagnosis, or medical impression must be documented related to the findings.
- Plan of action/treatment documented that is consistent with the diagnosis/impression and includes consultations, therapies, and prescribed regimens

- The identification of current problems, significant illnesses, and medical conditions should be documented on the problem list. If the member has no known medical illnesses or conditions, the chart must include a flow sheet for preventive health care.
- The medication list records past and current medications, including dosages and date of initial or refill prescription, should be reviewed with each patient encounter, and include the provider's initials and date indicating review of the medication list.
- Unresolved problems from previous office visits should be addressed in subsequent visits.
- When a member is treated at an emergency department, there should be a note acknowledging the visit (and the follow-up care, if indicated).
- Medical record should have a notation concerning follow-up care, call, or return visit. Time to return should be noted in days, weeks, months, or as needed (PRN).
- When a consultation is requested, there should be a note or report from the consultant in the record that contains the ordering/covering physician's initials and date indicating review.
- Labs, X-rays, imaging reports, and other referrals for ancillary services that have been requested should have reports or results filed in the medical record that contain the ordering provider's initials or other documentation indicating review. Consults, abnormal labs, and imaging results have an explicit notation in the record of follow-up plans.
- Hospital discharge summaries are included as part of the medical record for all hospitalizations that occur while the member is under the primary care provider's care.
- Documentation of preventive health services including, but not limited to, record of immunizations and age-appropriate screenings
- Documentation of advance directives, whether executed or not, for all members 18 years and older
- Pediatric records [members under twenty-one (21) years of age] should have a complete immunization record or notation regarding immunization status.
- Documentation of screening and counseling on tobacco use, alcohol use, substance use, and sexual activity for members 11 years of age and older
- Documentation of screening and counseling on nutrition, diet, and exercise, including height, weight, and body mass index (BMI) for adults. Height, weight, and documentation of BMI percentile or BMI percentile plotted on an age-growth chart for children ages 3–17 years.
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the member resides or the Department for Public Health
- Documentation of appropriate referral to consultants when applicable and evidence of correspondence from ancillary providers/facilities to primary care practitioners. This would include

hospital discharge summaries, discharge summaries from emergency room visits, home health follow-up, nursing home/skilled nursing facility follow-up, and discharge information from free-standing surgical centers.

- All written denials of service and the reason for the denial
- If any covered service provided by a provider requires completion of a specific form (i.e., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate state or federal regulations. The provider shall retain the form in the event of an audit, and a copy shall be submitted to the Cabinet or Aetna Better Health, upon request.

**A member's medical record shall include the following minimal detail for individual clinical encounters:**

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; C. Plan of treatment including:
    - Medication history, medications prescribed, including the strength, amount, directions for use and refills
    - Therapies and any other prescribed regimen
    - Follow-up plans, including consultation, referrals, and directions, including time to return

**A member's medical record shall include, at a minimum, for hospitals and mental hospitals:**

- Identification of the Enrollee
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 [mental hospitals] or 42 C.F.R. 456.70 [hospitals]).
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42

  C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals) Reasons and plan for continued stay, if applicable.

**Other supporting material appropriate to include for non-mental hospitals only:**

- Date of operating room reservation and
- Justification of emergency admission, if applicable.

# Utilization Management (UM) Program

## Utilization Management

The Aetna Better Health Utilization Management (UM) program ensures that our members receive quality services that are medically necessary, meet professionally recognized standards of care, and are provided in the most effective and medically appropriate setting. Our program provides a mechanism for prospective, concurrent, and retrospective review of services and treatments provided.

## Program Oversight

The Quality Management/Utilization Management Committee (QMUM), comprised of Aetna Better Health participating providers, medical directors, and management staff, is granted the authority and primary responsibility for continuous oversight of the UM program by the Board of Directors. The UM program is overseen by the Director of Health Services.

## Utilization Management Staff

Our utilization management staff is comprised of experienced, licensed personnel, such as physicians, registered nurses, licensed practical nurses, and other certified ancillary health care professionals. The UM staff is supervised by a registered nurse with extensive managed care experience. All nurses and behavioral health clinicians are licensed. All non-licensed staff work directly under the supervision of a licensed staff member. All physical and behavioral health medical necessity determinations that do not meet criteria are made by appropriately board-certified physicians. If you have questions about our utilization management processes, we want to hear from you. You can reach our knowledgeable staff during business hours.

For any questions about UM processes or an UM issue, please call our toll-free member service line at **1-855-300-5528** from 7 a.m. to 7 p.m. ET, Monday through Friday.

- After normal business hours, you may leave a voice message or send a fax.
- Calls will be returned during normal business hours, unless otherwise agreed upon.
- Our licensed behavioral health clinical staff members are available 24/7 at **1-888-604-6106** for crisis management and urgent admission determinations.
- To make sure you are speaking with an authorized Aetna Better Health of Kentucky representative, all staff will identify themselves by name and title and will indicate that they represent Aetna Better Health of Kentucky during all inbound and outbound calls.

### Appropriate Utilization of Care without Conflict of Interest nor Incentives

We don't reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities, for not authorizing health care services. No individual is compensated or provided incentives to encourage denials, limited authorizations, or discontinuation of medically necessary covered services. Aetna Better Health does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood or on the perceived likelihood that the practitioner or staff member supports, or tends to support, denial of benefits.

Individuals shall not participate in the review and evaluation of a case in which he/she has been professionally involved or where his/her judgment might be compromised. Utilization decisions are made based only on appropriateness of care and service and existence of coverage.

Aetna Better Health has utilization and claims management systems in place to identify, track, and monitor the care provided to members to ensure that appropriate health care is provided to the members. The following processes are in place to ensure appropriate utilization of health care:

- A process to monitor for over and under-utilization of services and to ensure that appropriate steps are taken if identified
- A system to support the analysis of utilization statistics, identification of potential quality of care issues, implementation of intervention plans, and evaluation of the effectiveness of any actions taken
- A process to support continuity of care across the health care continuum

All providers within the ABHKY network should make available covered services in terms of timeliness, amount, and duration as outlined in this manual to all Aetna Better Health members. In addition, all facilities, service locations, and adequate personnel must be accessible to Aetna Better Health members.

## Prior Authorization, Concurrent Review and Retrospective Review Criteria

The term Prior Authorization (PA) is the utilization review process used to determine whether the requested service, procedure, or medical device meets the company's clinical criteria for coverage.

To support prior authorization, concurrent review, and retrospective review decisions, we use nationally recognized evidence-based criteria with input from health care providers in active clinical practice. We apply these criteria based on medical necessity and appropriateness of the requested service, the individual member's circumstances, and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision.

Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and as nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners in developing, adopting, or reviewing criteria. The criteria are consistently applied, considering the individual needs of the members, and allow for consultations with requesting practitioners/providers, when appropriate.

### Prior Authorization

The prior authorization process supports:

Verification of current member eligibility based on the information available from the Commonwealth via KYHealthNet at www.https://public.kymmis.com

- The review of the service requested based upon the available benefit plan for the member
- The evaluation of medical necessity of services based on the type of service, level of care, and network availability as mandated by the Aetna Better Health contract with the Commonwealth of Kentucky
- Accurate claims adjudication
- Identification of members that may benefit from a referral to integrated care management

**Required Information**

Please provide the following information for each service when requesting authorization:

- Member name
- Ordering provider name and NPI (Group name and Group NPI)
- Aetna Better Health and/or Kentucky Medicaid number
- Date of birth
- Expected date of service
- Diagnosis
- Service requested, and modifier if TCM services
- Significant medical information related to the diagnosis and service requested
- Name and NPI of provider/facility rendering service (Group name and NPI)

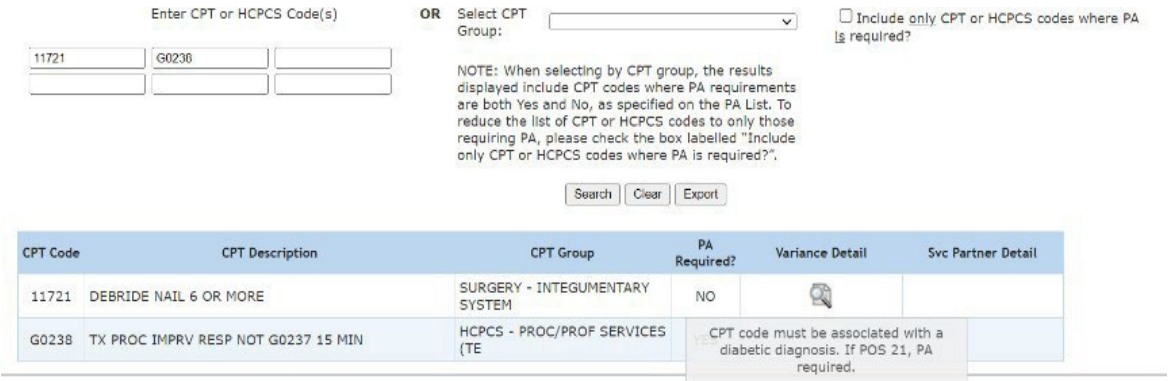
**Prior Authorization List**

For a comprehensive listing of authorization requirements by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes, please visit Availity at https://apps.availity.com/availity/web/public.elegant.login and refer to the prior authorization tool/directory. Please check the variance detail on ProPat AetnaBetterHealth.com/Kentucky/providers/prior-authorization.html

If you do not have access to Availity, we recommend that you register immediately.

- Click here to learn more about Availity Portal Registration: https://apps.availity.com/availity/Demos/Registration/index.htm
- Click here to register: https://www.availity.com/provider-portal-registration
- For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday-Friday (excluding holidays).

You can also search ProPAT, our online prior authorization search tool, which includes a list of services that require authorization. Please remember to check the variance detail. AetnaBetterHealth.com/Kentucky/providers/prior-authorization.html




**Services Requiring Authorization**

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing and other health services before care is provided.

For a comprehensive and current listing of authorization requirements, please **visit ProPat for prior authorization requirements and details.**
Prior Authorization | Aetna Medicaid Kentucky

If a provider performs a service that is medically necessary, that has not already been prior authorized, the provider can submit the authorization request within five (5) business days of the service being performed. When submitting a request, all pertinent clinical information must accompany the request. Requests received or authorization change requests beyond five (5) business days post service will be denied for timely notification.

**Requesting Authorization**

Medical providers may request authorization and submit notification Monday-Friday between the hours of 8 AM – 6 PM ET. The form is available on our website.

Behavioral Health providers may request authorization and submit notification 24 hours a day, 7 days a week. The form is available on our website:
AetnaBetterHealth.com/Kentucky/providers/library

Here are the ways you can ask for Prior Authorization:

**Fax** the request form to:

- Outpatient Physical Health: **1-855-454-5579**
- Outpatient SKY Medical: **1-833-689-1422**
- Outpatient Behavioral Health: **1-855-301-1564**
- Outpatient SKY Behavioral Health: **1-833-689-1424**
- Behavioral Health Psychological and Neuropsychological Testing: **1-844-885-0699**
- Physical Health or inpatient concurrent review requests: **1-855-454-5043**
- Physical Health retrospective reviews: **1-855-336-6054**

**Call** us toll free:

- Outpatient Medical: **1-888-725-4969**
- Behavioral Health: **1-855-300-5528**
- Physical Health or inpatient concurrent review: **1-888-470-0550**

Submit Online through **Availity** Portal: https://apps.availity.com/availity/web/public.elegant.login

**Medical Necessity Criteria**

Aetna Better Health has a comprehensive UM program that reviews services for medical necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. We comply with federal and state regulations when selecting medical necessity criteria and have adopted Milliman Clinical Guidelines (MCG) as the primary medical/surgical criteria for medical necessity. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Clinical Guidelines (MCG) guidelines are updated regularly. For substance use treatment, we will use the American Society of Addiction Medicine (ASAM) criteria. If MCG does not cover a behavioral health service, we will adopt the following standardized tools for medical necessity determinations:

- For adults, Level of Care Utilization System (LOCUS)
- For children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS).
- For young children; Early Childhood Service Intensity Instrument (ECSII).

If it is determined that a medical necessity criterion is not available or is not specifically addressed for a service or for a specific population, Aetna will submit its proposed medical necessity criteria to the Department of Medicaid Services (DMS) for approval. CMS recognized guidelines, Local Coverage Determination criteria (LCDs) and National Coverage Determination criteria (NCDs), may be used by Aetna when other criteria do not specifically address the provider request. DMS may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not otherwise covered by the named criteria. Aetna will implement such criteria within ninety (90) days of receipt of notice from the Department.

Aetna's medical necessity criteria is readily available for review by the Department or the public by request and is available on Aetna's website.

Aetna has written policies for applying criteria. For prior authorization of elective inpatient and outpatient physical health medical services, Aetna Better Health of Kentucky uses the following medical review criteria consulted in the order listed. If Milliman Clinical Guidelines (MCG) guidelines state "current role remains uncertain" for the requested service, the next criteria in the hierarchy should be consulted and utilized (this also applies to concurrent review and non-elective conditions):

- Criteria required by applicable state or federal regulatory agency
- Milliman Clinical Guidelines criteria/ASAM criteria
- Aetna Medicaid Pharmacy Guidelines
- EviCore criteria for pain management, specified radiology, and cardiology services
- Nationally recognized standards
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

Aetna has in place policies and procedures to ensure consistent application of review criteria for the processing of initial and continuing authorization of services. Aetna will obtain all necessary

information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate, when processing requests. Prior authorization, concurrent review, and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above.

Aetna's Medical Management Committee which includes representation by Kentucky licensed health care professionals, reviews internally developed medical necessity criteria and attests to the criteria being used for medical necessity decisions annually. Aetna will submit changes to previously approved criteria to the Department's Medical Director for review and approval.

Medical and behavioral health management criteria and practice guidelines are disseminated to all affected practitioners/providers, members, and potential members upon request by contacting Aetna Better Health's Member Services at **1-855-300-5528**. Criteria is also readily available for review on our website at https://www.aetnabetterhealth.com/kentucky/index.html.

## Communication with Members Regarding Treatment

Providers may freely communicate with members about their treatment, regardless of benefit coverage limitations.

## Concurrent Review

Concurrent review is composed of clinical and non-clinical staff. The concurrent review clinician will perform a medical necessity review for each hospitalization. Hospital admissions will be reviewed and followed for discharge needs. Subsequent reviews are conducted on a schedule determined by the member's reason for admission, type of facility, and its location. The concurrent review clinician will indicate to the facility a timeframe in which additional clinical information should be submitted. When the level of care does not meet the criteria or guideline standards, the case will be referred to an Aetna Better Health of Kentucky medical director for review and determination.

Concurrent review may be conducted on-site, telephonically, or by fax. Pertinent clinical information needed with each review includes, but is not limited to, the following:

- Current symptoms, complaints, vital signs, diagnosis, etc.
- Attending and/or consulting physician notes
- Diagnostic test results
- Laboratory results
- Current orders/treatment
- Ongoing treatment plan
- Discharge needs

Once a review is completed, the authorization number, number of days approved, and level of care approved is issued to the hospital and/or attending provider. The attending provider and the facility are sent written notification of any adverse determination. When possible, the member's PCP is also provided electronic/written notification of adverse determinations to facilitate care coordination, to assure that the physical and behavioral health needs of members are identified, and to assure that the services are facilitated and coordinated with all service providers, individual members, and family, if appropriate, and authorized by the member.

### Medically Necessary

Medically necessary services, supplies, procedures, etc., are those covered benefits or services that are:

- Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy
- Appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good medical practice
- Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons
- Provided in the most appropriate location regarding generally accepted standards of good medical practice where the service may, for practical purposes, be safely and effectively provided

- Needed, if used in reference to emergency medical services, using the prudent layperson standard
- Provided in accordance with EPSDT requirements established in 42 U.S.C. 1396(r) and 42 CFR 441, Subpart B for individuals under age 21
- Provided in accordance with 42 CFR 440.230

## Medical Necessity Decisions

Decisions are made in accordance with our contractual guidelines as outlined in the inpatient/outpatient services section. If a question of medical necessity or appropriateness arises, the case will be reviewed by a medical director. Providers must understand that Kentucky Medicaid reserves the right to change benefits from time to time. Aetna Better Health will notify

## Decision and Notification Standards

We adhere to the following timeframes when notifying the requesting provider, member, and servicing provider of prior authorization, concurrent review, and retrospective review decisions:

| Type of Request | Decision/Notification Timeframe | Notification to | Notification Method |
|---|---|---|---|
| Urgent Pre-Service Review | Within twenty-four (24) hours of receipt of the request | Practitioner/ Provider and Member | Electronic/Written |
| Non-Urgent Preservice Review | Within five (5) business days of receipt of the request* | Practitioner/ Provider and Member | Electronic/Written |
| Urgent Concurrent Review | Within twenty-four (24) hours of the receipt of the request | Practitioner/ Provider and Member | Electronic/Written |
| Post-Service Review | Within five (5) business days of the receipt of the request | Practitioner/ Provider and Member | Electronic/Written |

*The timeframes for decisions and notification may be extended if additional information is needed to process the request.

If we need more facts, documents, or information to decide, we will request it from the appropriate practitioner within the decision timeframes in the above table. The timeframes for non-urgent preservice requests may be extended if information is not received and the provider or member request an extension. The practitioner will have up to fourteen (14) days to submit the additional information for review We also notify members of the extension outlining the requested information needed on the date we request it from the practitioner.

- If the practitioner provides the additional information within fourteen (14) days, we will approve or deny the service and notify the member, member's PCP, and prescribing

practitioner according to the timeframes in the table above.

- If we do not receive the requested information within fourteen (14) days, we will approve or deny the service based upon the available information and notify the member, member's PCP, and prescribing practitioner according to the timeframes above.

## Notice of Action

Requests not approved are communicated to the requesting provider, member, and provider of service in writing within required timeframes. The notice of action will outline the member's and provider's right to additional review.

## Retrospective Review

Retrospective reviews are conducted when providers or practitioners request a review after a service or procedure has been provided. Aetna Better Health of Kentucky performs retrospective reviews for services/admissions, with extenuating circumstances or that the member was determined to be retroactively eligible only. In the absence of extenuating circumstances or when a claim has already been filed, providers must submit a written request for a formal appeal as explained in the Appeals Rights.

Requests for retrospective reviews must be submitted within twelve (12) months from the date of service, or in the case of retroactive eligibility twelve (12) months from the date the member was added to our membership roll.

## Peer-to-Peer Reviews

Our medical directors participate in the utilization review process and conduct clinical reviews. They are available to discuss review determinations with attending physicals or other ordering providers. Providers can request a peer review within 5 business days from the date of the adverse benefit determination. We will notify practitioners/providers electronically or in writing, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. From the date of the adverse determination, we will schedule, complete and notify the provider of the final decision within 14 calendar days. We schedule with the medical director's first availability.

## Authorizations

This section describes the authorization processes and requirements for services provided to Aetna Better Health of Kentucky members.

### Authorization Confirmation

Upon approval of the requested service, Aetna Better Health will supply the following either verbally or via fax within the notification standards listed above:

- Authorization number
- Timeframes for which the authorization is valid
- Total number of days/visits/services approved

### Authorizations and Claim Submission

The prior authorization number must be in the appropriate box on the claim forms for services that require an authorization. Items to consider when adding the authorization number to the

claim form:

- Include the number in box 23 of the CMS claim form or box 63 of the UB form.
- Verify that dates of services on the claim fall within the authorized services and date ranges.
- Electronic data interchange (EDI) and paper claims should contain the authorization number in the requested field.

The Cabinet updates eligibility daily. Members must be eligible on the date of service. A prior authorization number does not guarantee payment if the member is not eligible, or benefits are not available on the date the service is rendered. Please remember, a provider must verify a member's eligibility prior to rendering a service. Aetna Better Health will not pay for a service provided to a member not eligible on the date of service.

## Inpatient Admissions

PCP offices or attending provider specialists must contact the Prior Authorization Department for a preadmission review of any elective inpatient admission that requires prior authorization.

## Medical Claims Review

We identify certain claims to determine whether services were delivered as prescribed and consistent with our payment policies and procedures. In these instances, our medical claims reviewers determine whether the documentation provided supports the billing and whether billed charges are necessary and reasonable, and to identify non-covered supplies and services as well as inappropriate and undocumented charges. The medical claims reviewers report any cases of potential fraud or abuse to our Compliance Department for review.

## Discharge Planning

Discharge planning begins on admission and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention.

The goal of discharge planning is to initiate cost-effective quality treatment interventions for post-hospital care at the earliest point in an admission to ensure appropriate utilization of services. Discharge planning is a collaborative effort between the attending physician, hospital discharge planner, Aetna Better Health clinical staff, ancillary providers, and community resources to coordinate care and services.

The discharge plan considers the member's age, prior level of functioning, significant past medical history, anticipated discharge location, current medical condition including diagnosis, current level of functioning, family/community support, psychosocial factors, and potential barriers to discharge planning. The discharge plan may include referral to covered specialty programs and/or a variety of services or benefits to be utilized upon discharge (e.g., transfer to inpatient skilled nursing, sub-acute care or rehabilitation facility, home health care, community services, or durable medical equipment).

Our concurrent review clinicians assist hospital staff in coordinating appropriate individualized discharge plans for members' post-hospital care. The concurrent review clinicians assist with, but do not duplicate, discharge services that Medicare, Medicaid, and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) require hospitals to provide.

Our post-hospital planning function is carried out under the direction of the Chief Medical Officer by concurrent review clinicians who are responsible for:

- Coordinating member's post-hospital discharge planning with facility personnel
- Documenting a member's hospital discharge plans upon the initial review and ongoing as needs are identified
- Documenting a member's discharge date and status within twenty-four (24) hours of knowledge of the discharge
- Determining whether a care management and/or disease management case needs to be referred to further assist the member with his/her/their health care needs

We will work with your discharge planners to address any discharge needs regarding the member. Here are the phone and fax numbers:

- Discharge Planning Fax: **1-877-815-8746**
- Discharge Planning Toll Free Phone: **1-855-619-9281**

### Observation Stays

Observation and ancillary services do not require notification for participating providers. Aetna Better Health of Kentucky will reimburse up to forty-eight (48) hours of medically necessary care for a member to remain in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge.

As an Aetna standard, observation care is usually not expected to exceed twenty-four (24) to forty-eight (48) hours. If observation services result in an inpatient admission, notification must be made to Aetna Better Health of Kentucky UM Department within one (1) business day.

Effective April 15, 2023, ABHKY began following the eight-hour minimum rule for observation status pertaining to same-date admission and discharge only. While this rarely happens, if a member is admitted to observation status and is discharged in fewer than eight hours those charges will be considered incidental.

## Specialty Provider Referrals

Aetna Better Health does not require PCPs to obtain authorizations to refer members to participating specialists for office level service except for:

- Second opinions – only non-participating second opinions require prior authorization. A referral is not needed for in-network provider second opinions. Supportive Managed Care Program (refer to the Supportive Managed Care Program).

The specialist must provide communication to the PCP by fax, email, postal mail, or telephone within two (2) weeks of the member visit. This communication promotes continuity of care and reduces the risk of duplicating services and/or treatments that could place the member at risk. Failure to provide a report to the PCP violates billing reimbursement guidelines that could result in an audit and/or reimbursement recovery to Aetna Better Health.

Referring a member from the specialist office to another participating provider specialist must only occur with the prior approval of the member's PCP, when the services in question are of a non-emergent nature.

Once this PCP approval has been obtained, the specialist is responsible for coordinating any support documentation for the referral to the provider specialist and PCP. This documentation must be available at the time of the member's visit to ensure continuity of care and timely implementation of an appropriate treatment plan as well as to reduce the risk of duplicating services and/or treatments that could place the member at risk.

**Note:** Services referred to a non-participating specialist must have prior approval from Aetna Better Health.

### Oncology Treatment Plan

Requests for oncology medications (chemo agents and supportive drugs) and radiation therapy are handled by our third-party vendor, Eviti. Treatments should be submitted via the website (https://connect.eviti.com).

If you need assistance with Eviti, support can be reached at 1-888-482-8057.

### Second Opinions

Our members and providers have the right to a second opinion any time the member disputes Aetna Better Health, the plan benefit administrator, and/or physician's opinion on a request for services and/or treatment.

Our members will incur no expenses for a second opinion provided by a participating or non-participating provider authorized by Aetna Better Health. All second opinions by a non-participating provider require prior authorization from Aetna Better Health and may be initiated by contacting the Prior Authorization Department.
Aetna Better Health will reimburse any non-participating provider for a second opinion at the Aetna Better Health of Kentucky Medicaid Fee Schedule rate in effect at the time of service. We require any service and treatment approved after the second opinion be performed by the participating provider initiating the request.

Aetna Better Health may request a second medical opinion when the procedure and treatment does not meet established authorization criteria. The member will incur no expense for a second medical opinion requested by Aetna Better Health. The provider will be selected from the Aetna Better Health panel of provider advisors.

The provider advisors will review all available medical documentation and may request further medical information and/or diagnostic testing to complete a review for a second opinion. The member may decline to participate in a second opinion that involves an examination or diagnostic testing. In this case, the original Aetna Better Health determination of the medical necessity or appropriateness will be upheld.

## Non-Participating Provider Referral Request

Aetna Better Health allows members to receive medically necessary services and treatment by a non-participating Medicaid provider when the expertise necessary to support the best outcome is not available within the network.

Requests to refer the member out of network must have prior authorization from Aetna Better Health before services are to be rendered, except for the following:

- Emergency services
- Foster care
- Family planning
- HIV screenings
- Tuberculosis (TB) screenings

The non-participating provider shall be reimbursed in accordance with the payment to out-of-network providers. The referral will be established with a set number of visits and/or treatments with individual timeframes for the case to reevaluate the need for continued services.

Transition of the member's care back to a participating Aetna Better Health provider will be reviewed collaboratively with the attending provider, the Aetna Better Health provider that can appropriately accept management of the care, and the Aetna Better Health case manager and/or Medical Director.

## Hysterectomy Protocol

Hysterectomies are covered only if the beneficiary has been informed verbally before surgery that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign the Commonwealth's Hysterectomy Consent form. All items on the form must be completed, and the form must be signed by the beneficiary (or representative) and the physician (MD or DO). This form must be submitted with the claim since no authorization is required for hysterectomies.

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy. In the event of an emergency surgery in which the required form is not completed, a physician's statement that prior acknowledgment was not possible is required for reimbursement consideration.

Please refer to the document library on the Aetna Better Health website at AetnaBetterHealth.com/Kentucky for a copy of the Hysterectomy Consent form.

## Sterilization Procedures Policy

Aetna Better Health is required to comply with the standard Commonwealth of Kentucky and federal regulations regarding sterilization procedures. The following criteria must be met for payment consideration:

- The member must be at least 21 years of age.
- The member must be mentally competent at the time the surgery is performed.
- The waiting period from the time the consent form is signed to the day of the surgery must allow for a full 30-day waiting period but not to exceed 180 days from the consent date.

- The member must be eligible with Aetna Better Health on the date of service.

The form must be submitted with the claim since no authorization is required for sterilization. Reimbursement cannot be made to the provider if the Commonwealth requirements are not met. Please refer to the document library on the Aetna Better Health website at AetnaBetterHealth.com/Kentucky for a copy of the Sterilization Consent form.

### Elective Admissions and Outpatient Surgeries

Elective hospital admissions and select outpatient surgical procedures require prior authorization. Contacting the Aetna Better Health Prior Authorization Department prior to scheduling elective services minimizes any scheduling conflicts if issues related to network access, benefit availability, and/or medical necessity arise during the prior authorization process.

At a minimum, the request for services must be made five (5) working days prior to the date of service to promote a timely determination. Providing the following information at the time of the request will expedite the prior authorization process:

- Member name and date of birth
- Aetna Better Health member ID number and/or Kentucky Medicaid ID number
- Expected date of admission
- Primary diagnosis
- Significant medical history related to the diagnosis and/or treatment plan request
- Previous treatments and procedures initiated for the same diagnosis
- Planned procedure or treatment plan
- Attending provider name
- Facility where services are to be rendered

The prior authorization associate will issue an authorization number for the initial day of the admission once the review is approved. Subsequent days will be reviewed periodically for medical necessity, appropriateness of level of care, and benefit availability.

When the member requires continued stay associated with the elective procedure, Aetna Better Health of Kentucky requires notification of admission within one business day. The Concurrent Review clinician will issue an authorization number for the admission once the review is approved. Subsequent days will be reviewed periodically for medical necessity, appropriateness of level of care, and benefit availability. Notification of Admission requests can be faxed to the Concurrent Review fax number at **1-855-454-5043**.

The Concurrent Review clinician will review for continued stay and level of care approval. Notification on the level determination will be given to the appropriate utilization management staff at the hospital, outpatient center, rehab, and/or skilled facility on the day of the review determination.

All late notifications of elective admissions or outpatient surgical procedures are subject to denial based on lack of timely notification. In the event the stay or admission is not denied, the request will be reviewed for medical necessity, appropriateness of level of care, and benefit availability. Notification of the level(s) approved during a retrospective review will be provided to the appropriate utilization management staff upon completion of the review process. This process

may include a referral to the Medical Director for clinical review determination.

## Urgent Admissions

Urgent admissions must be presented to the Concurrent Review Department within one (1) business day of the service being initiated.

If a member presents to a provider with commercial insurance information, the provider will be afforded forty-eight (48) hours from the admission date to verify commercial coverage and to inform Aetna Better Health if commercial coverage presented was incorrect. At the time Aetna Better Health is notified, the supporting clinical information is to be provided for authorization determination. The admitting provider must notify the member's PCP of the admission. This timely notification promotes continuity of care for the member during the admission/stay and with coordination of care after discharge.

Review of the clinical information for the urgent admission will be completed per existing decision and notification standards provided in this manual. Health Services will provide the determination decision for the initial admission date based on medical necessity, appropriateness of level of care, and benefit availability as well as network accessibility.

The Aetna Better Health concurrent review clinician will review for continued stay and level of care approval. Notification of approved, reduced, or denied days will be given to the appropriate utilization management staff at the hospital, rehab, or skilled facility on the day of the review determination.

## Experimental and Investigational

A health product or service is deemed experimental if one or more of the following criteria are met:

- Any drug not approved for use by the Food and Drug Administration (FDA); an FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or any drug that is classified as IND (investigational new drug) by the FDA. As used herein, the definition of off-label prescribing is prescribing prescriptions drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval.
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

This policy applies to all Aetna Better Health members unless superseded by applicable law.

## Outpatient Hospital Services

Aetna Better Health contracts with area hospitals and free-standing facilities to provide outpatient services such as, but not limited to, preventive health screenings, diagnostic testing, therapeutic and/or palliative care, and surgical services. Select services rendered in an outpatient setting require prior authorization. Please visit Availity or contact the Prior Authorization Department if you are unsure if the service and/or treatment requires authorization.

You may reach the Prior Authorization Department at
**1- 888-725-4969**, Monday–Friday, 8AM - 6 PM ET.

When providing outpatient services, remember to verify member eligibility prior to rendering non-emergent services and/or treatments.

The Aetna Better Health of Kentucky prior authorization associates are available if you need clarification on the required prior authorization number, what services and/or treatments have been authorized, and to verify the expiration date of the authorization.

## Limitations and Exclusions

Limitations and exclusions of inpatient/outpatient services and treatments include, but are not limited, to:

- Personal convenience items, such as televisions, radios, or telephones in the member's room
- Any extra charges for a private room
- Cosmetic surgery except when to restore function or deemed medically necessary
- Care for service related to disabilities for which members are entitled to benefits through military, federal, or state programs
- Inpatient stays that are not medically necessary or appropriate as determined by Aetna Better Health
- All inpatient days prior to a scheduled surgical procedure unless specifically authorized by Aetna Better Health

## Home Care Services

Home health care and home infusion services require prior authorization. Home care services should be coordinated with the member's PCP or the referring provider specialist in accordance with the member's treatment plan. Coverage determinations will be based on medical necessity, available benefit, appropriateness of setting, and network availability.

Authorizations for home care and/or home infusion always include the number of visits and a date span for the services. Requests to extend the date span or increase the number of visits should be requested in advance by calling the **Prior Authorization Department at 1-888-725-4969**, Monday–Friday, 8 a.m.–6 p.m. ET. Failure to obtain prior authorization will result in claim denials for these services.

## Durable Medical Equipment/Orthotics/Prosthetics/Supplies

Select DME, orthotics/prosthetic, and supplies require prior authorization. Any DME exceeding $500 billed charge will require prior authorization. Supplies exceeding the allowable quantity will also require prior authorization. Please refer to the Availity website for a complete authorization listing: https://apps.availity.com/availity/web/public.elegant.login

Requests which require prior authorization should be coordinated with the member's PCP or the referring specialty care provider and be in accordance with the treatment plan. Coverage determinations will be based on medical necessity, available benefit, appropriateness of setting, and network availability. Failure to obtain prior authorization will result in claim denials for these services.

## Transition of Care

Aetna Better Health supports the transition of new members who actively receive health care services by authorizing the service or treatment while awaiting medical necessity documentation for the service/treatment requested. The availability of supporting clinical documentation at the time of the request will expedite additional visits and/or treatment approval.

New members will not be without medically necessary medical supplies, nutrition supplements, pharmaceutical products, physical/occupational/speech therapy, psychological counseling, home care services, personal care, etc. during the transition period, even if those services and/or treatments are provided by non-participating providers. Approval for medically indicated supplies and services will be provided on an interim period, approximately one (1) visit, evaluation and/or month of supplies in the event medical necessity is not provided at the time of the request.

Continued authorization of medical supplies or services must be medically necessary. Transition to a participating provider for the services will be required if the non-participating provider will not be entering into a contractual relationship with Aetna Better Health

# Quality Improvement

## Quality Improvement Program Description

Aetna Better Health maintains a quality management program that promotes objective and systematic measurement, monitoring, and evaluation of services and that implements quality improvement activities.

## Quality Management Oversight Committee (QMOC)

Aetna Better Health of Kentucky's Board of Directors has delegated oversight of the Aetna Better Health Quality Improvement (QI) program to the Quality Management Oversight Committee. This Board of Directors meets frequently and reviews and approves the QI program documents (i.e., program description/strategy, work plan, and evaluation).

The Quality Management Oversight Committee (QMOC) reports to the Board of Directors. The QMOC meets at least quarterly. Approved minutes are maintained of all committee meetings. The meetings are chaired by the Aetna Better Health Chief Executive Officer or designee and include Aetna Better Health of Kentucky senior leadership who are involved in the Quality Improvement Program activities. The Committee reviews and approves QI program documents (i.e., Program Description/Strategy, Work Plan, and Evaluation). The Committee's oversight includes, but is not limited to, quality improvement projects, assessment of progress in quality improvement initiatives, the monitoring and evaluation of the quality of care and service, credentialing and re-credentialing functions, utilization management functions, and oversight of all delegated functions. The QMOC Committee is responsible for evaluating, implementing, and monitoring the effect of quality improvement policies, procedures, and programs to continuously improve the quality of medical care and services provided to members. Annual summaries for the results of the QI program are available on the website at AetnaBetterHealth.com/Kentucky or by calling the health plan at **1-855-300-5528**.

## Quality Management/Utilization Management (QM/UM) Committee

The QM/UM is a sub-committee of the QMOC (Quality Management Oversight Committee) that provides physician review of, and recommendations on, the health plan's Quality and Utilization Management programs to the QMOC to ensure sufficient clinical input. The Committee is an advisory committee whose recommendations are forwarded to the QMOC for review and consideration. The Committee is chaired by the Chief Medical Officer or designee. Committee members are actively practicing providers of various specialties and health professions who are in the Aetna Better Health provider network. Aetna Better Health staff members include the Director of Health Services, Director and Manager of Quality Improvement, Director of Utilization Management, and other reporting staff members, as applicable. The QM/UM Committee meets at least quarterly.

Approved minutes are maintained of all committee meetings. The QM/UM responsibilities include:

- To review and make recommendations on quality improvement studies and surveys, clinical indicators, and member and provider interventions
- To review clinical criteria, practice guidelines, and protocols, to review demographic, disease, and program specific data and to recommend clinical indicators to be monitored and interventions to be pursued

- To review the results of quality improvement activities, to monitor progress in meeting quality improvement goals, and to suggest needed actions to ensure appropriate follow-up
- To conduct a professional review activity involving the professional competence or conduct of practitioners or providers whose conduct adversely affects, or could adversely affect, the health or welfare of patients

**Goals and Objectives**

The goal of the Quality Improvement program is to facilitate consistent delivery of high-quality, coordinated member care and service throughout Aetna Better Health by assessing and improving care/service processes and outcomes.

The objectives of the Aetna Better Health Quality Improvement program are as follows:

- Design and maintain structures and processes that support continuous quality improvement, including systematic measurement, analysis, intervention, and re-measurement. This includes mechanisms to evaluate and improve member care outcomes.
- Comply, coordinate, and monitor for compliance with Commonwealth and federal regulations and NCQA standards. This includes attending and participating in the Commonwealth Quality Assurance and Improvement Advisory Group meetings.
- Coordinate, integrate, and communicate quality improvement activities with other departments, including Member Services, Network Relations, Financial Services, Claims, Utilization Management, and Information Services
- Monitor and evaluate medical care provided to Aetna Better Health members to ensure quality and medical appropriateness, identify over and underutilization, and ensure safety of services through prospective, concurrent, and retrospective review
- Monitor and evaluate the behavioral health care provided to Aetna Better Health members to ensure accessibility, quality, and safety of services as well as continuity and coordination of behavioral and medical care
- Conduct and oversee clinical and non-clinical performance improvement projects (PIPs) that demonstrate an ongoing measurement and intervention improvement in member care, service, safety, and satisfaction
- Monitor credentialing and re-credentialing activities
- Educate enrollees, health plan staff, and providers on the importance of Quality and Utilization Management programs and the results of non-confidential studies or reports (i.e., HEDIS® and Consumer Assessment of Healthcare Providers and Systems [CAHPS] via newsletters and the Aetna Better Health website)
- Measure availability and accessibility to care and service quarterly
- Measure member satisfaction and identify sources of dissatisfaction through:
    - Review and analysis of member complaint data
    - Member satisfaction surveys
- `Measure provider satisfaction and identify sources of dissatisfaction through:
    - Review and analysis of provider complaint data
    - Provider satisfaction surveys

- Provide members a mechanism to offer suggestions for improving internal operations and services through participation on the Quality Member Access Committee and through the health plan's review of enrollee complaints and appeals
- Address specific concerns identified by the plan's clinical or administrative staff
- Establish clinical practice guidelines, including preventive health, pertinent for the population and annually measure compliance via HEDIS® measures and other applicable measures and standards
- Measure compliance to medical record standards on a random number of physicians
- Integrate the Quality Improvement Systems for Managed Care (QISMC) into the overall quality strategy
- Monitor standards for oversight of subcontracted vendors and for delegated entities for quality improvement, credentialing/re-credentialing, utilization management, and claims processing
- Develop methods to evaluate continuity and coordination of care
- To support objectives aimed at the development, monitoring, and servicing of members with complex health needs in conjunction with care management
- Monitor cultural and linguistic needs to ensure processes are in place to serve a diverse membership
- Accurately record documentation of QI investigations and activities, including documentation of quality improvement committee meetings, qualitative and quantitative reports of trends/patterns, and analysis of the trends/patterns
- Evaluate, at least annually, and modify as necessary:
    - The effectiveness of quality improvement interventions for the previous year (demonstrated improvements in care and service) and trending of clinical and service indicator data
    - The appropriateness of the program structure, processes, and objectives
    - The work plan for the upcoming year that includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues

**Scope of Quality Improvement Program**

The Aetna Better Health Quality Improvement program encompasses all aspects of clinical care and services for all members and providers. Our Population Health management program functions within Quality and focuses on meeting the care needs of our enrollees throughout the continuum of care.

Information is reviewed and analyzed on an ongoing basis. Program reviews will be conducted on targeted and randomly selected providers and diagnoses on a continuous basis. This information is then incorporated into the work plan.

The program addresses members with special needs in the monitoring, assessment, and evaluation of care and services provided. Emphasis is placed on, but not limited to, clinical areas relating to women, infants and children, adolescents, and young adults. Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) HEDIS® and non-clinical areas, such as member satisfaction and provider satisfaction, are also included in the comprehensive effort to improve outcomes of care and service.

The Aetna Better Health Quality Improvement Program includes components to monitor, evaluate, and implement the Commonwealth contractual standards and processes to improve:

- Quality management
- Utilization management
- Population health management

- Health Equity and Social Determinates of Health (SDOH)
- Records management
- Information management
- Care management
- Member services/enrollee satisfaction survey
- Customer Assessment of Healthcare and Providers Systems (CAHPS) surveys
- Provider services
- Organizational structure
- Credentialing/re-credentialing
- Network performance
- Fraud and abuse detection and prevention
- Access and availability to care and services
- Data collection, analysis, and reporting
- Compliance with NCQA and state standards
- HEDIS® reporting requirements
- Medicaid Managed Care Performance Measures
- Preventive care
- Review of translation line utilization to identify specific cultural/linguistic needs
- Peer review
- Performance Improvement Projects (PIPs)
- Oversight of subcontractors and delegated activities
- Continuity and coordination of care
- Annual QI work plan
- QI program effectiveness annual evaluation

**Continuous Monitoring for Quality of Care and Service by Providers**

In support of our mission to provide quality health care to our members, Aetna Better Health has established formal processes for reviewing adverse events and quality of care issues, reporting to NPDB/HIPDB, and a formal peer review program. The Quality Improvement Department, under the direction of the Medical Director, is responsible for continuously monitoring quality of care and services provided by our provider network and to monitor compliance with applicable federal and state regulations as required by the Aetna Better Health contract with the CHFS. Processes in place to continuously monitor quality of care and services include credentialing, a peer review process, medical record reviews (as applicable), and reviews of all reported adverse events and quality of care issues, such as:

- Any unexpected death or physical/psychological injury resulting from treatment
- Other member issues relating to care and/or service (i.e., medical mismanagement or delay in treatment)

To govern any disputes between the provider and Aetna Better Health that could ultimately result in a change in the network status of the provider, a provider dispute resolution process has been established. Aetna Better Health will notify providers of any issues regarding non-compliance, professional competency, and/or conduct. For non-compliance, at a minimum, the following steps will take place:

- At least one (1) written notification letter is sent to the provider notifying him/her of the issue and the relevant Aetna Better Health policy, including the potential for corrective action.
- Upon determination that the provider has not complied with the Aetna Better Health participation

requirements, the Medical Director may initiate corrective action. Corrective actions may include, but are not limited to, counseling, practice restrictions, and termination of provider's participation, imposing summary suspension if such action is necessary to protect the member's health and welfare and notifying the medical group of which the provider is a member that corrective actions have been imposed.

- The Medical Director may refer the issue to an appropriate committee for review and recommendations. If the recommendation is contract termination, the provider will be notified immediately by certified mail.

- The Medical Director or designee or the Credentialing Committee may recommend termination of the Aetna Better Health provider for substandard performance, failure to comply with administrative requirements, or any other reason.

The Medical Director or designee may immediately suspend or restrict any provider if the Medical Director determines that the health of Aetna Better Health members or any individual referred by Aetna Better Health to the provider for care is in imminent danger or jeopardy because of the actions or inactions of a participating provider. Also, in his/her sole discretion, the Medical Director (or designee) may determine that an Aetna Better Health provider may be subject to disciplinary action, including termination pursuant to the credentialing plan, including immediate suspension or restriction of the provider's participation status, during which time Aetna Better Health will investigate to determine if further action is required.

An opportunity to appeal any corrective action is available to all providers. A hearing to appeal the imposition of action is available to a provider against whom a final adverse action is recommended if the practitioner submits a written request within thirty (30) days after the date of the notice letter. The Peer Review Committee hears all requested provider hearing appeals. The Peer Review Committee may uphold, modify, or reject corrective actions. For specific details or additional information, a copy of the following policies is available upon request.

- Quality Improvement Medical Record Review
- Quality of Care Issue Review and Adverse Event Monitoring
- National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB) Reporting Process
- Peer Review Program
- Provider Dispute Resolution

For additional information or copies of policies related to provider ongoing monitoring and the provider oversight dispute resolution process, please contact your Network Relations Manager.

### Practitioner Sanctioning Policy

- Sanctions must be reported to Aetna Better Health if balance billing
- Failure to comply with PIP requirements

### Provider On-Going Monitoring

The Aetna Better Health policy and process for ongoing provider monitoring, including on-site visits and medical record quality reviews, are based on recommendations from the National Committee for Quality

Assurance (NCQA), regulatory requirements, and Kentucky Medicaid requirements. The policy and procedure are reviewed, revised if necessary, and approved by the Executive Quality Improvement Committee on an annual basis. Provider on-site evaluations may be completed by a Network Relations Manager and/or a registered nurse from the Quality Improvement Department. Medical record reviews are completed by registered nurses in the Quality Improvement Department.

The provider agrees to permit Aetna Better Health staff, any federal or state agency having jurisdiction over the provider's provision of services to members and/or the U.S. Department of Health and Human Services, and any accrediting organization to conduct periodic site evaluations of provider's facilities, offices, and records. Upon written request from Aetna Better Health, a provider shall deliver Aetna Better Health with a copy of the written response to any questions or comments posed by the agencies listed in the preceding sentence.

The Quality Improvement Department completes on-site provider evaluations and medical record reviews as follows:

- As needed related to a quality of care, member safety or accessibility issue, concern, complaint, or grievance warranting an on-site investigation by QI. (Warranting a complete investigation, a resolution of the issue cannot be achieved by requesting a copy of the medical record and phone or other communication with the provider.)
- As needed for completion of HEDIS® medical record data abstraction and to meet other regulatory and accreditation requirements

The Medical Director may immediately suspend or restrict any individual provider or group of providers if the Medical Director, in his/her sole discretion, determines that the health or safety of Aetna Better Health members or any individual referred by Aetna Better Health to a provider for care is in imminent danger or jeopardy because of the actions or inactions of a provider.

To govern any disputes between the provider and Aetna Better Health that could ultimately result in a change in the network status of the provider, a provider dispute resolution process has been established.

## Clinical Practice Guidelines

Aetna Better Health endorses a variety of nationally recognized clinical practices, preventive care, and behavioral healthcare guidelines. Clinical practice, preventive care, and behavioral healthcare guidelines made available by Aetna Better Health are not a substitute for the professional medical judgment of treating physicians or other health care providers.

Evidence-based clinical practice guidelines are based on information available at a specific point in time and during review and adoption by the Quality Management/Utilization Management Committee (QM/UM). The most current guidelines are published and made available through a variety of professional organizations, such as the American Academy of Pediatrics, the American Academy of Family Practice, the National Institute for Health, the American Psychiatric Association, and the American College of Obstetrics and Gynecology. The guideline review and update process are implemented for each guideline at least every two (2) years. Reviews are more frequent if national guidelines change within the two-year period.

The Clinical Practice and Preventive Health guidelines are available on the Aetna Better Health of Kentucky website at AetnaBetterHealth.com/Kentucky/providers/clinical-guidelines-policy- bulletins.html. A hard

copy of the guidelines is available to providers upon request. A provider can request a copy by contacting their Network Relations Manager. Disclosure of clinical guidelines is not a guarantee of coverage.

## Preventive Service Guidelines

Aetna Better Health adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention. When there is lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. The guidelines are adopted to facilitate improved health care and to reduce unnecessary variation in care. They are not intended to direct coverage, benefits determinations, or treatment decision.

| | |
|---|---|
| Preventive Service Guidelines | U.S. Preventive Services Task Force (USPSTF) |
| Immunization Schedules | CDC |

## Preventive Health Services

These documents are updated on an annual basis. Caution is advised as recommendations often change. The online summaries of recommendations do not represent benefits; not all recommended services are necessarily covered by a member's health plan. Therefore, members must refer to their plan documents, contact their employer's benefits department, or contact Member Services directly for coverage information.

The following links provide the immunization schedules:

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger

Recommended Immunization Schedule for Adults Aged 19 Years or Older

## Provider Participation

Provide r participation is an integral component of the Aetna Better Health quality improvement program. Participating providers are given a structured forum for input on credentialing, clinical criteria, peer review, and quality improvement activities through representation on Aetna Better Health committees.
The Quality Improvement program is under the leadership of the Chief Medical Officer. Requests for committee participation should be directed to the Aetna Better Health Chief Medical Officer and/or the Aetna Better Health Director of Quality Improvement.

## Medical Record Management

Aetna Better Health providers are responsible for maintaining medical record systems that ensure the following:

- Confidentiality of protected health information (PHI)
- Records are kept current in a detailed, organized, and comprehensive manner that permits effective member care and quality review (See section 1. C. Medical Record Documentation Standards)
- Records are available and accessible for quality review in accordance with the Health Insurance Portability and Accountability Act (HIPAA)

Aetna Better Health providers are responsible for maintaining records according to federal and state requirements and applicable accreditation standards, such as NCQA.

Providers and health care facilities shall comply with the following, at a minimum, regarding the maintenance, retention, and disposal of medical records:

- Maintain a member record for each individual for whom medical services were provided.
- Maintain the records for a minimum of seven (7) years from the date of service unless federal or state law or medical practice standards require a longer retention period; and
- Maintain the records in a way that protects their integrity and ensures their confidentiality, proper use, and accessibility and availability to each member as required by law.
- Each provider should ensure that member health information is available to meet the needs of continued member care, legal requirements, research, education, and other legitimate uses.
- The American Health Information Management Association (AHIMA) recommends that medical records for adults be maintained for ten (10) years after the most recent encounter and that medical records for children be maintained until the age of majority plus the statute of limitations.
- Aetna Better Health contracts require that providers cooperate with QI activities including, but not limited to, providing access to provider medical records to the extent permitted by state and federal laws. Medical records may be reviewed on-site or requested for review to meet state requests, for the collection and submission of HEDIS® data as required by state law and Kentucky Medicaid requirements, and to meet other accreditation requirements.
- Providers maintain the confidentiality of member information and records.

## Quality Management Provider Overview

The primary purpose of the QAPI Program is to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance enrollee and provider satisfaction across the various settings of care within the care delivery system.

The QAPI Program strives to ensure that the services provided to Aetna Better Health of Kentucky enrollees conform to the standards and requirements of regulatory and accrediting agencies, including the Department of Medicaid Services and the National Committee for Quality Assurance (NCQA).

Further, the purpose of the QAPI Program is to establish standards and criteria and to provide processes, procedures, and structures to review and monitor the care and service delivered, including accessibility, availability, and continuity of care. The Quality Department staff coordinates organizational participation in the assessment of quality of care, identification of issues and strategies to mitigate, as well as follow-up activities and documentation.

The purpose of the Quality Management program includes the following:

- Promotion of improvement in the quality of care provided to enrollees through established processes, including:
    - Monitoring, evaluating, and identifying areas for improvement in the service delivery system and provider network
    - Implementing action plans and activities to correct deficiencies and/or improve overall quality in the process of care and clinical operations

- Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.
- Compliance with federal and state requirements
- Executive and management staff participation in the quality management and performance improvement processes
- Development and implementation of quality management and performance improvement activities that include contracted provider participation and information provided by enrollees, their family/representative, and/or caregiver
- Identification of the best practices for quality management and performance improvement
- Continuous review, evaluation, and improvement in the quality and safety of clinical care and services considering demographic groups, races, ethnicities, enrollees with special or complex health needs, and care settings and types of services provided to a culturally and linguistically diverse membership. Aetna Better Health of Kentucky integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions and monitoring activities. Staff perform monitoring activities as a part of routine operations and report results to the appropriate internal departments, committees, or external agencies as required.

## Value Based Programs

At Aetna Better Health of Kentucky, we value the role you play in providing the highest quality care to your patients – our members. We also understand that improving the health outcomes of our members requires a level of collaboration between us – you as the professional who provides the care, and Aetna Better Health of Kentucky as the health plan that covers the care. To show you how deeply we are committed to working with you, we are proud to share our Value Based Programs.

All of our Value-Based Programs are based on quality parameters we collect in our state processes. There are multiple programs that reward providers for meeting or exceeding quality goals. By meeting or exceeding the quality goals, providers are eligible to earn incentive payments, while delivering the highest quality health care to our members.

**Our Value-Based Programs support your patients and our quality care initiatives by:**

- Promoting care that results in a healthier population by improving quality and outcomes
- Enriching care delivery consistency and adherence to evidence-based standards of care
- Promoting a continuous quality improvement orientation
- Promoting care coordination between providers and the health plan, resulting in greater alignment of goals for our members' health

Aetna currently has and will continue to seek out VBP arrangements for both physical health and behavioral health providers. Our current VBP model captures arrangements with FQHCs as well as with PCPs, general practitioners, registered nurses, and pediatricians.

To support providers in their transition from pay-for-volume to pay-for-value by improving access, quality, and affordability, Aetna Better Health currently has:

- **Performance-Based Reimbursement**
    - Providers are eligible for incentives tied to both clinical and financial outcomes. Incentive payments are based on performance of selected metrics and targets designed to reduce avoidable utilization and deliver high quality care.
- **Care Management Collaboration**
    - Care management support is provided through the use of technology, tools, and locally based clinical resources to assist providers in coordinating care for members.
- **Performance Reporting & Analysis**
    - Reporting and analysis are available to support providers in understanding their performance and identifying key gaps and areas of opportunity to achieve success.

Aetna Better Health continually evaluates its network for opportunities to partner with providers and provider groups to determine the mutual advantages of moving towards a value-based arrangement on a case-by-case basis.

## Healthy Home Visits

The annual healthy home visit is a unique benefit opportunity for adult members to spend up to an hour with a Kentucky licensed physician or nurse practitioner in the comfort and convenience of their home. In partnership with Signify Health, the largest provider of mobile practitioners in the country, ABHKY provides members with a personal and compassionate service that identifies and addresses challenges that are not evident during a doctor's visit. This does not replace the members' primary provider visits but enhances the visits they have with them in the future.

The purpose of the home visit is to gather additional health and quality data from your patient and to understand social and environmental factors obtained from the patient's home that may be affecting their health. Signify Health healthcare providers will review and document medical history and current medications as well as social determinants of health needs. The assessment also may address existing health conditions and services received that you may not be aware of as they may have been diagnosed and provided by other physicians, such as specialists. All Signify Health clinicians are trained and board-certified doctors, nurse practitioners, and physician assistants and are enrolled in the Kentucky Medicaid Program.

## Copy or Access to Member Medical Records

The medical record is the property of the provider who generates the record. All member records must be made available to authorized representatives of the Cabinet upon their request.

Upon written request of a member, guardian, or legally authorized representative of a member, the provider/Aetna Better Health shall furnish a copy of the medical records of the member's health plan history and treatment rendered within thirty (30) days of the initial request. Members are entitled to one (1) copy of their medical record per year at no cost to the member. The fee for additional copies shall not exceed the actual cost of the time and materials used to compile, copy, and furnish such records.

It is important that medical record information be provided in a timely manner when a member requests a PCP and/or specialty provider change to ensure adequate coordination and a safe transfer of member care and services. Aetna Better Health requests that medical record(s) be transferred to a new provider within ten (10) business days of receipt of the request.

## Confidentiality

Confidential information is any information that is revealed during a confidential relationship. It includes communication between the member, provider, and/or other clinical persons involved in the member's medical, psychiatric, and/or substance use care.

### Release of Information

Valid authorization must be obtained from the member or member's personal representative to use or disclose PHI for purposes other than treatment, payment, or health care operations.

### Storage

Medical records should be stored by providers in an area that does not allow for unauthorized retrieval. Member records located at Aetna Better Health are maintained in a locked file cabinet.

### Transfer of Medical Records

It is important that medical records are transferred in a timely manner when a member requests a PCP and/or specialty provider change. Aetna Better Health requests that medical records be transferred to a new provider within ten (10) business days of receipt of the request.

PCP panel listings, including new members, are available on Availity at https://apps.availity.com/availity/web/public.elegant.login and available upon request.

Aetna Better Health encourages providers to use this list to contact new members for appointments and request copies of their medical records.

### Medical Records Retention

Medical records, including appointment logs and sign-in sheets, must be maintained and preserved for a minimum of seven (7) years from termination of the Aetna Better Health contract.

## Member Safety

In November 1999, the Institute of Medicine's (IOM) Committee on Quality Health Care in America released a comprehensive report regarding medical errors in the health care system, "To Err is Human: Building a Safer Health System." The report cited startling statistics including that 44,000 Americans die annually due to medical errors. It presented recommendations that call for action to reduce these errors at a number of different levels. Specifically, it suggested that health care organizations and accrediting bodies do the following:

- Require health care organizations to implement meaningful member safety programs
- Focus greater attention on performance measures and standards for both health care organizations and health care professionals on member safety

Aetna Better Health has responded to these developments by including an emphasis on member safety in the Quality Improvement program and developing policies and procedures to meet the requirements of the final rules that implement Section 2702 of the Member Protection and Affordable Care Act (72 Federal

Register 32816 (2011)). Several activities are in place to monitor aspects of member safety. The National Quality Forum's recommended adverse event list has been combined with the CMS list of hospital-acquired conditions and other events identified by Aetna Better Health to be used for quality-of-care adverse event monitoring and reporting. Providers' credentials are verified in accordance with NCQA standards, plus monitoring of disciplinary action against providers occurs on an ongoing basis.

## Advanced Health Care Directive

Aetna Better Health is required to provide education about advanced directives to providers, staff, and members. Advanced directives provide the right for any member to participate in and direct their own health care decisions, to accept or refuse medical or surgical treatment, and to prepare an advance directive which is documented in writing.

All Aetna Better Health providers are required to inform members of their individual rights under state laws governing advanced directives. Providers need to document member advanced directive information in the member medical record. As part of the medical record review process, Aetna Better Health audits applicable medical records to determine compliance with advanced directives policies and procedures.

Providers are required to notify members to what extent he/she will honor a member's advanced directive. Providers may not discriminate against a member who does not have an advanced directive. Providers are required to document member advanced directive information in the medical record.
Providers should also provide ongoing community education on advanced directives.

Federal law directs that most health care providers give adults information about their rights under state laws about advanced directives. The laws include:

- The right to participate in and direct your own health care decisions
- The right to accept or refuse medical treatment
- The right to prepare an advanced directive
- The right to information about whether a provider will honor your advanced directives

The law:

- Prohibits institutions from discriminating against people without an advanced directive
- Requires institutions to document individual's information regarding advanced directives
- Requires institutions to provide ongoing community education regarding advanced directives

An advanced directive is a tool for health care decisions when a person cannot speak for themselves. It tells providers what future health care wishes the member has if he/she is too sick to say. This is the only time an advanced directive is used. You should talk to members who are 18 years of age or older about their wishes, fears, and medical options.

**Types of Advanced Health Care Directives**

There are two types of advanced health care directives:

- Living will
- Durable power of attorney for health care

A living will is a legal document with written instructions spelling out any treatments a member wants or does not want if unable to speak for himself/herself when terminally ill or permanently unconscious.

A durable power of attorney for health care is a document that allows a member to name a person to make medical decisions if the member cannot. This person will act as the member's agent when treatment decisions need to be made, and the member cannot make them. Agents can only make decisions about the specific treatment areas described in the power of attorney.

**Who needs an advanced directive?**

Because illness and injury can happen at any time, all adults should consider having an advanced directive, even if they are in good health now.

It is every member's choice and right to sign an advanced directive. No insurance company or provider can force a person to sign an advanced directive. Members can change or stop an advanced directive at any time. An advanced directive does not change insurance coverage.

**Where can I get an advanced health care directive?**

A durable power of attorney for health care and advanced health care directive forms may be available through a health care provider, a local public library, or the Kentucky Bar Association at:

Kentucky Bar Association 514 W. Main Street Frankfort KY 40601-1812
Telephone: **502-564-3795**

The following resources may also be helpful:

- Office of the Kentucky Attorney General**:** www.ag.ky.gov
- American Bar Association: www.abanet.org/aging/toolkit/home.html
- Aging with Dignity: www.agingwithdignity.org
- Kentucky Bar Association: www.kybar.org
- National Hospice and Palliative Care Organization**:** www.caringinfo.org
- Children's Hospice International: www.chionline.org

## Healthcare Effectiveness Data and Information Set (HEDIS®)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. Aetna Better Health of Kentucky collects this data routinely.

**Frequently Asked Questions**

**1) Why do health plans collect HEDIS® data?**

The collection and reporting of HEDIS® data are required by the Center for Medicare and Medicaid Services (CMS). Accrediting bodies, such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS® data. The HEDIS® measures are related to many significant public health issues, such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

**2) How are HEDIS® measures generated?**

HEDIS® measures can be generated using two different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)

**3) Why does the plan need to review medical records when it has claims data for each encounter?**

Medical record review is an important part of the HEDIS® data collection process. The medical record contains information, such as lab values, blood pressure readings, and results of tests that may not be available in claims/encounter data. Typically, a plan employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information.

**4) How accurate is the HEDIS® data reported by the plans?**

HEDIS® results are subjected to a rigorous review by certified HEDIS® auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

**5) Is patient consent required to share HEDIS® related data with the plan?**

The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality, related health care operations of the health plan, including HEDIS®, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the plan's HEDIS® purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

**6) May the provider bill the plan for providing copies of records for HEDIS®?**

Unless otherwise stated in the contract, providers may not bill either the plan or the member for copies of medical records related to HEDIS®.

**7) How can provider reduce the burden of the HEDIS® data collection process?**

We recognize that it is in the best interests of both the provider and the plan to collect HEDIS® data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the providers EMR to the plan. Please contact a Network Relations Manager or the Quality Improvement Department for more information at **1-855-300-5528**.

**8) How can providers obtain the results of medical record reviews?**

The plan's Quality Improvement Department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the plan overall. Please contact a Network Relations Manager or the Quality Improvement Department for more information at **1-855-300-5528.**

**Helpful HEDIS® Documentation Tips for Providers**

We have developed a Tips Sheet regarding documentation guidelines when providing HEDIS®-related services. This can be found on our website at AetnaBetterHealth.com/Kentucky/providers/hedis.
Look under the HEDIS Provider Education tab for the complete list.

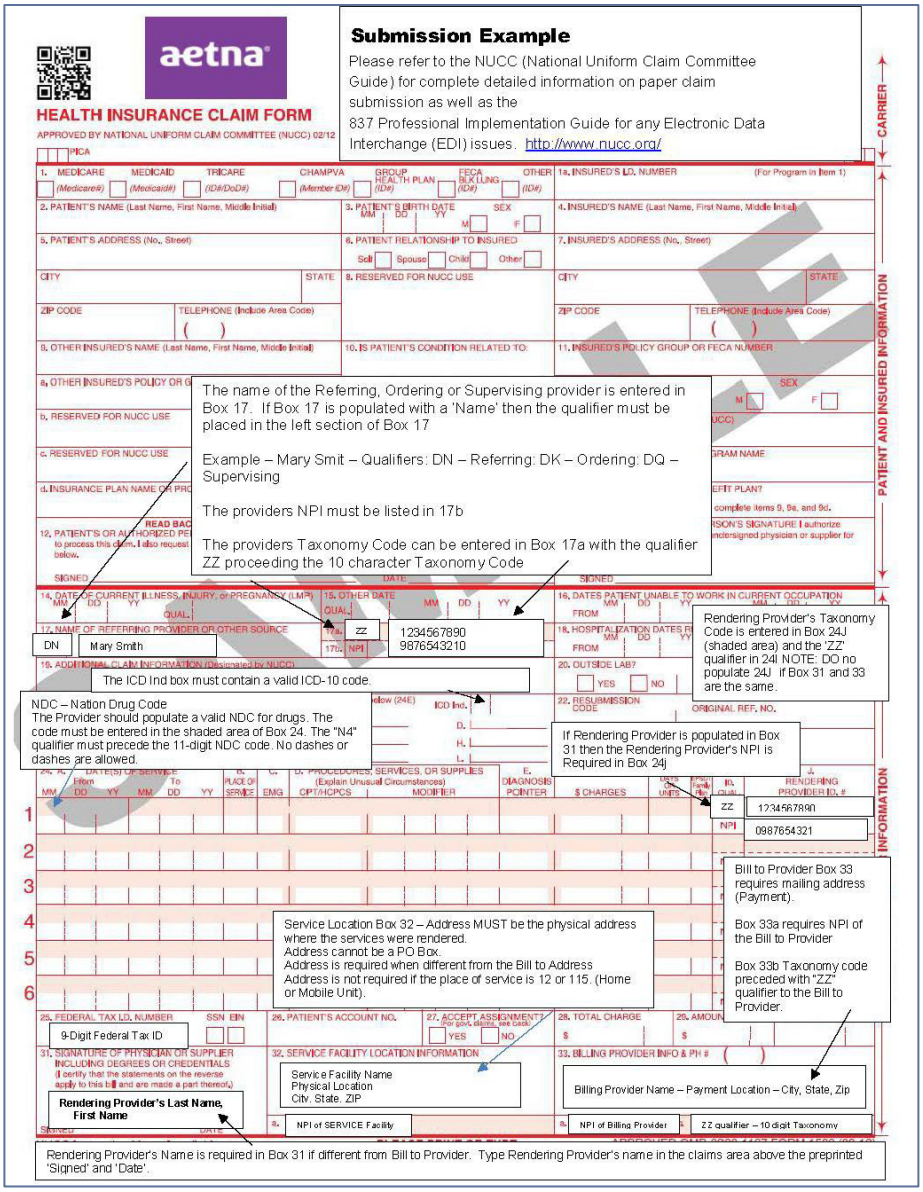
Providers may also contact the HEDIS® Department to schedule on-site or webinar based HEDIS® training. Please call **1-855-737-0872** to speak with a HEDIS® Outreach Coordinator to schedule this training.

# Billing Guidelines

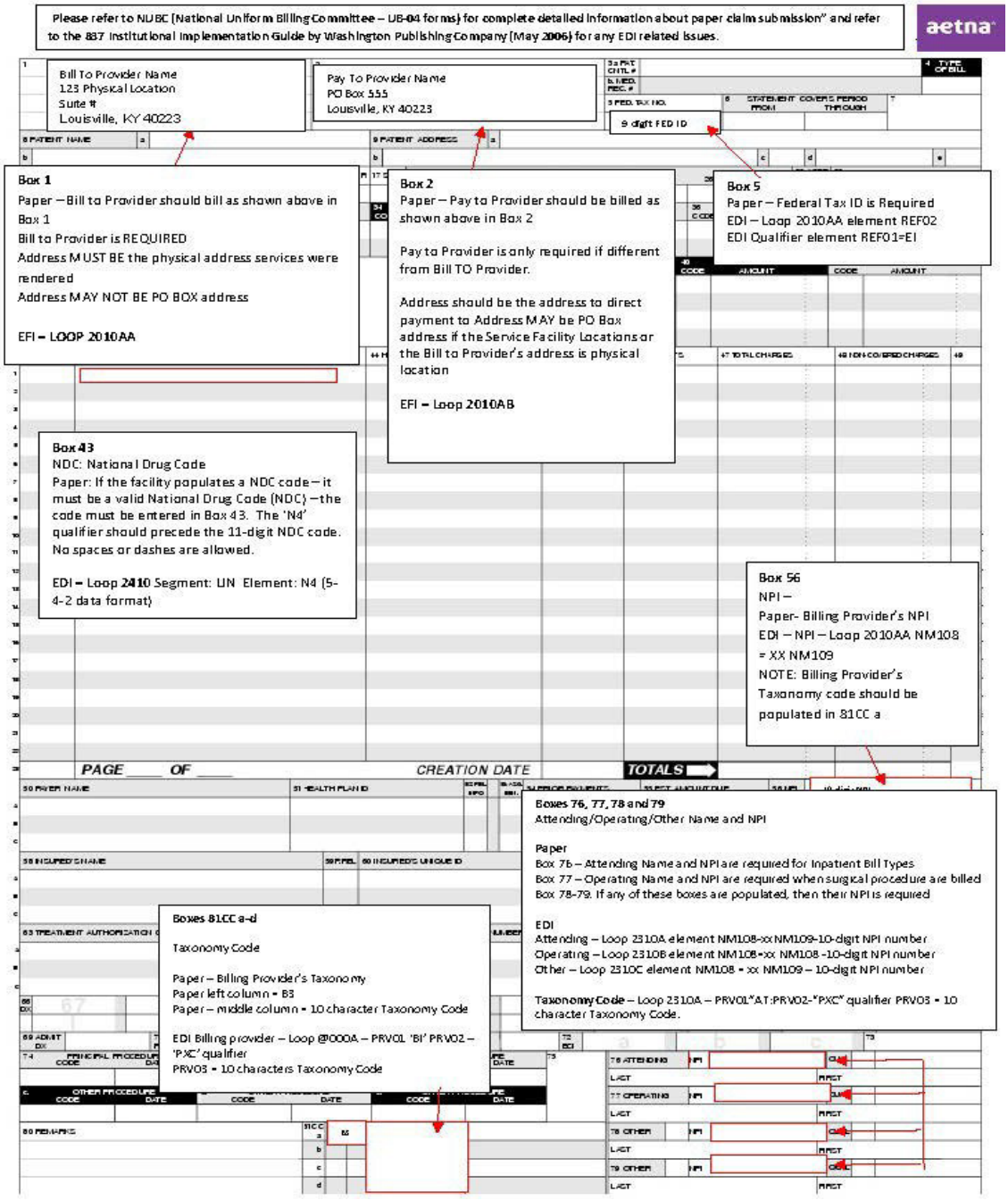
## Claim Forms (CMS and UB)

All claims must be submitted on a standard claim form and contain the basic data elements necessary for processing. For additional information on the standard CMS form visit www.nucc.org, and for the UB form visit www.nubc.org. These include, where applicable:

| Block | CMS |
|---|---|
| 01-A | Insureds ID |
| 02 | Patient name |
| 03 | Patient DOB and gender |
| 04 | Insureds name |
| 05 | Patient address & telephone # |
| 06 | Patient relationship to the insured |
| 10 | Patient condition relationship |
| 11 | Insured's information |
| 13 | Patient or authorizing person assignment of payment |
| 14 | Illness, injury, pregnancy date |
| 21 | Valid diagnosis code (s) |
| 23 | Authorization number |
| **For each procedure include:** | |
| 24A | DOS From |
| 24B | POS/Location |
| 24D | Procedure, services or supply code and modifier |
| 24E | Diagnosis Code |
| 24F | Amount Charged |
| 24G | Anesthesia Minutes or Units |
| 24J | Rendering Provider ID# PIN/Taxonomy/NPI |
| 25 | Federal Tax ID |
| 27 | Accept Assignment (gov) |
| 28 | Total Charges |
| 29 | Amount Paid |
| 31 | Phys Name Signature |
| 32 | Service Facility Info |
| 33 | Billing name, address, telephone for physician or supplier (Billing name should be listed as legal owner of TIN) |
| 33A | Billing NPI |
| 33B | Taxonomy Code |



| Form Locator | UB | Form Locator | UB |
|---|---|---|---|
| 1 | Billing Provider Name | 39-41 | Value codes |
| 2 | Facility pay-to name & address | 42 | Revenue code(s) |
| 4 | Type of bill | 45 | Service date (supplied by attachment is acceptable) |
| 5 | Federal tax number | 46 | Units of service |
| 6 | Statement covers period | 47 | Total charges (by revenue code category) |
| 8A | Patient name | 50 | Payer name |
| 9A | Patient address | 51 | Health plan ID |
| 10 | Patient date of birth | 56 | NPI |
| 11 | Patient gender | 58 | Insured's name |
| 12 | Admission/ State of care date | 60 | Insured's unique ID |
| 13 | Admit hour | 61 | Insured group name |
| 14 | Type of admission | 62 | Insured group number |
| 15 | Source | 63 | Treatment authorization number, unless not provided by plan |
| 16 | Discharge hour | 67 | Principal diagnosis |
| 17 | Patient status | 67 | Other diagnosis codes |
| 18 - 28 | Condition Codes | 69 | Admitting diagnosis code |
| 23 line | Page of, totals field and creation date | 70 | Patient reason dx |
| 29 | Accident State | 74 | Principal procedure code and date |
| 44 | HCPCS/Rates/HIPPS Rate codes 1-22 | 74 | Other procedure codes and dates |
| 31-36 | Occurrence codes and dates | 81 | Taxonomy |



## General Claims Information and Requirements

Aetna Better Health of Kentucky encourages all participating providers to submit electronic claims whenever possible. Electronic claim submission offers providers the fastest and most efficient claims adjudication and reduces office paperwork and mailing costs. Contact your Network Manager for additional information.

The following is a list of important general billing requirements for each claim submitted (this list is not exhaustive):

- Providers must have a current Commonwealth of Kentucky Medicaid provider identification number submitted with each claim. **Claims for providers without an active Kentucky Medicaid ID number will be denied**.
- Facility claims must be submitted on a UB form, with valid revenue codes, CPT, HCPCS modifier codes, and the correct type of bill. EPSDT services are an exception and may be billed on a CMS 1500.
- Professional and ancillary claims (non-facility) must be submitted on the current CMS 1500 form.
- List all other health insurance coverage when applicable (Block 9A-D of CMS form and Block 58-62 of the UB form). Aetna Better Health, as an agency of the Commonwealth, is the payer of last resort in most instances.
- Providers must submit an active NPI and taxonomy records that match the Commonwealth of Kentucky's provider file for the date of service. Claims not matching the provider file will be denied. See section "National Provider Identifier (NPI) Number and Taxonomy" for billing instructions.
- All providers, including FQHCs, RHCs, and Primary Care Centers, must submit their claims, listing their usual and customary charges as the billed amounts, on the applicable claim form.
- EPSDT screening services must be reported with the age-appropriate Evaluation and Management code along with the EP modifier. EPSDT claims must be billed on the CMS 1500.
- NDC is required for all drugs billed on a CMS 1500 or UB-04 claim form. Claims that do not include the NDC, valid unit of measure, and quantity will be denied as required by the Commonwealth of Kentucky.
- Revenue codes must be submitted with corresponding HCPCS or CPT codes as defined by the Commonwealth of Kentucky. Claim lines received with no corresponding code may be denied.
- Payment is always subject to member eligibility at the time of service. Please be aware that members must be eligible with Aetna Better Health on the date the service is provided. Due to "day specific eligibility" the provider is required to verify the member's eligibility by accessing https://www.kymmis.com/kymmis/index.aspx.

Providers may contact Aetna Better Health Customer Service at **1-855-300-5528** if assistance is needed. Aetna Better Health is not responsible for the reimbursement of services when Kentucky Medicaid has retroactively terminated a member's eligibility, even if authorization has been obtained.

To provide consistency among processes within the industry, starting August 1, 2024. ABHKY will perform fee schedule and/or rate updates without requiring notification from Provider. ABHKY will make Commonwealth of Kentucky directed rate changes effective within ninety (90) days from Company's earliest receipt of notification from either the Commonwealth of Kentucky or Provider. Claims will not be retrospectively adjusted. Providers can resubmit claims individually.

Of note, if you are a Critical Access Hospital, inpatient final reimbursement settlements will still be performed in accordance with your Agreement. This amendment does not impact any required inpatient final reimbursement settlements to Critical Access Hospitals.

## Taxonomy

Providers must submit NPI and correct taxonomy code consistent with the provider's specialty and services being rendered and that is on the Commonwealth of Kentucky's provider file for the date of service. Claims submitted without this information or claims that do not match the Commonwealth's data will be denied.

Taxonomy codes are required on the CMS 1500 and UB claim forms.

On the CMS 1500 form, the rendering provider taxonomy must be submitted in box 24I and 24J (top of box, shaded area) – qualifier ZZ must be submitted in box 24I, and the taxonomy code submitted in 24J.

The billing provider taxonomy is submitted in box 33B – enter the 2-digit qualifier of ZZ followed by the taxonomy code. Do not enter a space, hyphen, or other separator between the qualifier and number (e.g., ZZ207Q00000X).

On the UB form, the billing provider taxonomy is submitted in field 81 – enter the 2-digit qualifier of B3 in the first column and then the taxonomy code immediately following the 2 –digit qualifier.

## Ordering, Referring, Prescribing, and Admitting (ORPA)

Effective April 1, 2017, Aetna Better Health of Kentucky implemented the requirement of the Center of Medicaid Services (CMS) for the Patient Protection and Affordable Care Act that requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe, and refer items or services for Medicaid recipients. This requirement applies to those ordering, referring, and prescribing providers who are enrolled with the contracted Medicaid Managed Care Organizations.

This change is designed to ensure that all orders, prescriptions, and referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from participation in Medicaid. The change requires providers to include the CMS Final Rule mandate that if items or services are ordered, prescribed, or referred by a resident or teaching physician they must be identified on the claim by his or her legal name and National Provider Identifier (NPI), and he or she must be an enrolled Medicaid provider.

**The providers that are eligible to be ordering, referring, prescribing, or attending providers are:**

| Provider Type | | Provider Type | |
|---|---|---|---|
| 60 | Dentist | 78 | Certified Nurse |
| 64 | Physician | 80 | Podiatrist |
| 74 | Nurse Anesthetist | 85 | Chiropractor |
| 77 | Optometrist | 95 | Physician Assistant |

The entry of Ordering or Referring Provider is required if the service is ordered or referred. However, from an encounter editing standpoint an ordering or referring provider must be entered by the following provider types:

| Provider Type | All Services Billed By: | Provide r Type | All Services Billed By: |
|---|---|---|---|
| 18 | Private Duty Nurse | 76 | Multi-Therapy Agency |
| 36 | Ambulatory Surgery | 79 | Speech Language |
| 37 | Independent Lab | 86 | X-ray/Miscellaneous |
| 50 | Hearing Aid Dealer | 87 | Physical Therapist |
| 52 | Optician | 88 | Occupational Therapist |
| 70 | Audiologist | 90 | DME Provider |
| **Provider Type** | **All Crossover Services Billed By:** | | |
| 54 | Pharmacy | | |

Provider type 34, Home Health Agencies (and all other providers submitting on the UB-04), are required to submit an attending provider on all their encounters.

This requirement also applies to out-of-state ordering, referring, and/or prescribing providers. These providers must also be enrolled in Kentucky Medicaid for services to be paid by Fee for Service (Traditional) Medicaid and with the contracted Managed Care Organizations should services be provided to impacted Medicaid recipients.

The ordering, referring, and prescribing information is required. Claims that are not billed correctly will be denied and will need to be corrected and resubmitted.

## Claim Coding

Claims must be submitted with valid CPT, HCPCS, revenue code, modifier, and NDC, if applicable.

Claims must be submitted with valid International Classification of Diseases (ICD)-10 Clinical Modification (CM) diagnosis codes and Procedure Coding System (PCS) to the highest degree of specificity to be considered valid that are age and gender appropriate.

Each CPT or HCPCS code line must have a valid place of service (block 24B) code when billing on a CMS form. Standard place of service billing codes noted below must be appropriately submitted on each CMS claim line to avoid rejection of the claim.

## Components of a" Clean" Claim

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a Commonwealth's claims system. If the revenue code requires a HCPCS code, then HCPCS must be billed.

Claims under investigation for fraud and abuse or medical necessity are not considered clean claims.

## ClaimsXten

Aetna better Health of Kentucky has migrated from Change HealthCare's ClaimsXten to Lyric ClaimsXten. As an enhancement, Coding Validation has been added, which is a front end edit that finds and manages incorrectly billed modifiers that override correct coding guidelines.

## Encounter Submission Requirements for Provider Type 01 (PT01)

To support accurate claims processing and reduce encounter rejections, providers billing under PT01 must adhere to the following submission standards. These requirements align with state guidance and internal audit findings.

**Duplicate Encounter Prevention (Edit 5001)**

Providers must submit claims in a manner that avoids triggering duplicate encounter rejections.

- **UB Inpatient**: Use a unique Billing Provider and ensure non-overlapping Statement Dates.
  - *Exception*: Claims may overlap if the Discharge Date of one claim equals the Admit Date of the next.
- **UB Outpatient**: Use a unique Billing Provider, non-overlapping Dates of Service, and distinct procedure codes, modifiers, and NDC codes (if applicable).
  - *Exception*: Service lines on the same claim will not duplicate against each other.
- **UB Inpatient Crossover**: Same as UB Inpatient.
- **UB Outpatient Crossover**: Same as UB Outpatient, with additional requirement that deductible and coinsurance amounts must be unique.
  - Revenue codes 450, 510, or 761 with condition code G0 will not reject if a paid claim exists without G0.
  - If a paid claim with G0 exists, the MCO must submit an adjustment encounter for the prior G0 encounter.
- **HCFA Crossover**: Use a unique Billing Provider, non-overlapping Dates of Service, and distinct procedure codes and modifiers.
  - *Exception*: Service lines on the same claim will not duplicate against each other.

Refer to the “Edit 5001 Duplicate Encounter Crosswalk” for a summary of duplicate logic by provider type.

**Valid Attending Provider Information (Errors: KYI178*, KYE178*)**

- Attending Providers must be active on the KY DMS Master Provider Layout (MPL) file with an active NPI on the claim’s Date(s) of Service.
- If the NPI maps to only one record on the MPL, submission via EDI must include a Taxonomy code paired with the active NPI.
- Attending Providers must be individuals, not organizations.
- Acceptable Provider Types:
    - Physician (Type 64)
    - Nurse Anesthetist (Type 74)
    - Certified Nurse Practitioner (Type 78)
    - Podiatrist (Type 80)
    - Physician Assistant (Type 95)

**Claim Type Restrictions**

- Providers may only submit on a HCFA form if the claim is a crossover (Error: KY_ProviderTypeClaimType

**Billing and Rendering Provider Requirements (Errors: KYE1836, KYE1003)**

- Providers must be active on the KY DMS MPL file with an active NPI on the claim’s Date(s) of Service.
- If the NPI maps to one record, EDI submission must include a Taxonomy code paired with the active NPI.

**Code Validity**

- Revenue Codes, Procedure Codes, Modifiers, and Diagnosis Codes must be active on the claim’s Date(s) of Service (Error: 0x3939612).

**Coordination of Benefits (COB) (Error: KYE2502)**

- When applicable, providers must submit:
    - COB payer name
    - COB paid amount
    - COB patient responsibility

**Member Eligibility Verification (Error: KYE2003)**

- Providers must verify member eligibility for the claim’s Date(s) of Service prior to submission.

**Coordination of Benefits (COB)**

Pursuant to federal law, Medicaid is the payer of last resort. As a Medicaid Managed Care Organization, Aetna Better Health will be considered the payer of last resort when other coverage for a member is identified. Aetna Better Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The only exceptions to this policy are claims for:

- EPSDT Special Services
- Maternity claims through postpartum (except delivery)
- Preventative pediatric services
- Children having other insurance through Title IV Court Support Order

If third party liability can be established, providers must bill the primary payer and submit a primary explanation of benefits (EOB) to ABHKY for secondary claim processing. In the event that coordination of benefits occurs, providers shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOB and other required documents. ABHKY may pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the provider requesting a refund including third party policy information required for billing.

Aetna Better Health of Kentucky has worked to develop a centralized commercial insurance bypass list for those specific procedure codes and modifiers typically deemed as not covered outside of Medicaid. This commercial bypass list allows providers to bill the KY Medicaid MCO directly without first billing an enrollee's commercial insurance for Coordination of benefit (COB) requirements. Kentucky healthcare providers must still attempt to bill the primary carrier as Kentucky Medicaid is the payer of last resort.

The referenced commercial bypass list can be found on our provider web portal or website at Commercial Bypass List. As a reminder, this commercial bypass process allows providers to bill directly to Kentucky Medicaid MCO without submitting an Explanation of Benefits (EOB), assuming that only procedure codes or modifiers on the bypass list are on the claim submitted. Otherwise, an EOB is still required.

Questions related to subrogation claims should be directed to Claims Customer Service at **1-855-300-5528**.

### Attestation Form:

If an EOB cannot be obtained from the commercial payer, then a centralized attestation form can be attached to the claim. The attestation form must be complete, legible, and applicable to the right member and provider in order to be considered valid and accepted by the Kentucky Medicaid MCOs for primary insurance processing. This form can be found on our provider web portal or website at Attestation Form.

This commercial bypass process is effective for dates of service effective May 1, 2023, and subject to change with advance notice. This commercial bypass process does not apply to any dates of service prior to May 1, 2023.

COB claims must be received by Aetna Better Health within 365 days from the member's primary carrier remittance advice date. A copy of the primary carrier remittance advice must accompany the claim.

Third Party Liability (TPL) claims will be pursued by Aetna Better Health based on requirements and/or limitations under the Aetna Better Health contract with the Commonwealth of Kentucky.

Providers who identify a member with primary insurance that has been terminated should call Member Services at **1-855-300-5528**. The coverage termination date should be clearly stated on the primary insurance letterhead or a primary insurance website screen print.

## Balance Billing/Hold Harmless

Providers shall accept payment in full for covered services rendered to members and such amounts as are paid by Aetna Better Health. Providers cannot charge or bill members for administrative or program fees associated with a covered service.

In no event (including non-payment by Aetna Better Health for covered services rendered to members by any provider for whatever reason, including claim submission delays and/or UM sanctions, insolvency of Aetna Better Health, or breach by Aetna Better Health of any term or condition of the agreement under which provider participates) shall provider bill, charge, or collect a deposition from, seek compensation, remuneration, or reimbursement from, or have any course against any member or a person (other than Aetna Better Health) acting on a member's behalf for covered services eligible for payment, nor shall provider bill a member or a person (other than Aetna Better Health of Kentucky) acting on a member's behalf for the difference between the covered charge and the negotiated rate or the amount provider has agreed to accept as full payment under the agreement for any amounts Aetna Better Health may owe provider or for any monies in excess of applicable co-payments, deductibles, or coinsurance, except as otherwise noted below. Provider shall in no event seek payment from any member for any service for which Aetna Better Health has denied payment on the grounds that provider has failed to comply with the requirements with respect to such service including, but not limited to, the failure of provider to obtain required preauthorization.

Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void.

Any provider who knowingly and willfully bills a member for a Medicaid covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent. Provider shall collect from the member and may retain only co-payments and deductibles.
In the event a member agrees in advance in writing to pay for a non-Medicaid service, then the provider can bill the member. A standard, detailed, easy-to-understand, release form must be signed by the member at the time of service and must specifically state the services or procedures that are not covered by Medicaid.

This does not prohibit provider from pursuing available legal remedies including, without limitation, collecting from any insurance carrier providing coverage to an individual. If it is reported that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health Network Relations Manager who is researching the report.

Failure to comply with these provisions may result in sanctions including, without limitation, loss of reimbursement, payment of any member's or Aetna Better Health's costs of defense, or collection arising out of such failure, up to and including financial penalties and/or termination of participation.

Provider further agrees that:

- The no balance billing provision shall survive the termination of the participation regardless of the cause giving rise to termination and shall be construed to be for the benefit of members and Aetna Better Health.
- This no balance billing provision supersedes any oral or written contrary agreement now existing or hereafter entered between provider and a member or a person acting on his/her behalf.

This provision shall be included in any subcontracts between provider and any other provider for the provision of covered services to plan members.

## Authorization and Claim Submission

Dates of service on the claim should fall within the pre-authorized service date range, if authorization is required. Authorization does not guarantee payment. Issues related to billing errors and member eligibility may cause a claim and/or claim line to adjudicate with a non-payment status.

## Claim Submission Address for Paper Claims

All paper claims for initial and corrected submissions must be submitted directly to Aetna Better Health at the following address:

Aetna Better Health of Kentucky
P.O. Box 982969
El Paso, TX 79998-2969

Each CMS 1500 corrected claim must clearly indicate "corrected" or "resubmittal," and the UB-04 corrected claims must use the appropriate type of bill to indicate a correction. All claim lines must be submitted on corrected claims.

## Electronic Claim Submission (EDI)

Aetna Better Health encourages all participating providers to submit electronic claims whenever possible. Aetna Better Health can receive initial and corrected claim submissions for both professional and facility claims. Electronic claims are NOT considered received until claims have passed clearinghouse edits and are accepted into the Aetna Better Health system. Providers must review all reject reports from the clearinghouse to verify acceptance, and payments are always subject to member eligibility on the date of service.

Aetna Better Health has implemented electronic claim filing in order to meet the Health Insurance Portability and Accountability Act (HIPAA) compliance standards. Additional electronic claim submission information is available online at https://www.aetnabetterhealth.com/kentucky. Please verify with your practice management vendor regarding file formatting and information on how to submit claims.

| Clearinghouse | Payor ID # | Claim type | Contact number |
|---|---|---|---|
| ECHO Health | 128KY | UB and CMS | 888-834-3511 |

## Electronic Submission of Corrected Claims

Corrected or replacement claims may be submitted electronically. Use the Claim Frequency Type Code (CLM05-3) in the 837 5010 EDI formats. A value in this field equal to "7" indicates a replacement claim. Additionally, Aetna Better Health accepts the following:

| Claim type frequency code (code set 235) | |
|---|---|
| Code | Meaning |
| 7 | Replacement of prior claim |
| 8 | Void/cancel of a prior claim |
| Any other code (including 1) submitted in the claim type frequency code will not be flagged in our system as a resubmission and will be adjudicated as an original submission. The above field code values are for 5010 professional claims. Institutional claims submission uses the same code values submitted in the last position of the type of bill field. | |

Corrected claims must include all original claim lines, including those previously paid correctly. Resubmitted claims without all original claim lines may result in the recoupment of correct payments.

## Timely Filing Guidelines

| Claim type | Timely filing guidelines |
|---|---|
| Initial claims (Outpatient/Professional/Ancillary Services) | 365 calendar days from the date of service (DOS) |
| Initial claims (Inpatient Services) | 365 calendar days from the date of discharge (DOD) |
| Retroactively activated member, including newborn claims | 365 calendar days from the date of enrollment into the Aetna Better Health eligibility files |
| Coordination of Benefits (all provider types) | 365 calendar days from date of primary carrier remittance advice |
| Adjusted/corrected claims | Providers have 24 months from the date of the first remittance advice to contact Aetna Better Health to request an adjustment or for Aetna Better Health of Kentucky to receive a corrected claim |

## Proof of Timely Filing

Acceptable proof of timely filing submissions by paper should be submitted as a claim attachment to the claims P.O. Box within the allotted adjustment period of up to 365 days from the date of service. Aetna Better Health considers the following as acceptable proof of timely filing:

- A computer printout, which shows the claim, and was generated and submitted to Aetna Better Health within the timely filing limits
- A copy of the EDI report showing the electronic carrier accepted the claim within the timely filing limits

- In case of providers who do not have a computerized billing system, other valid and credible documentation showing the claim was generated and submitted to Aetna Better Health within timely filing
- A copy of the other insurance carrier's EOB received twelve (12) months after the date of service but less than six (6) months after the other insurance carrier's adjudication date

- Claim front-end rejections are not considered clean claims

Provider inquiries regarding claims processing should be directed to Claims Inquiry and Claims Research at **1-855-300-5528**.

For claims not meeting the above acceptable proof of timely filing criteria, providers may initiate a request through the complaint and appeal process to have a specific claim and supporting documentation reviewed.
**Note**: A copy of a Kentucky Medicaid remittance advice or other Kentucky Medicaid managed care plan remittance advice is not considered acceptable documentation to override untimely filing. Member eligibility is date specific and should be confirmed at every visit or encounter.

## Electronic Funds Transfer (EFT)

EFT is an option for claims payment at no cost to our providers. Providers receive payment efficiently deposited directly into the provider's bank account. However, a print-ready PDF of your paper remittance advice is available through Availity at https://apps.availity.com/availity/web/public.elegant.login, or the Echo Provider Portal at: www.providerpayments.com

- To enroll in EFT, visit our website at ECHO Health Provider Login

Providers who do not enroll in EFT will receive claim payments through Virtual Credit Card (VCC) payment. VCC Payments work in the same way as other credit card payments:

- Providers receive a printed Explanation of Payment that includes a 16-digit card number.
- Enter the number and the full amount of the payment into your credit/debit point-of-sale terminal before the expiration date.
- Providers receive funds in the same timeframe as your other credit card payments.
- There is no need to enroll to receive VCC payments as they are processed under the merchant agreement with your banking partner.
- Note that your merchant/banking partner charges fees for the payment transactions. These fees are in lieu of the check clearing fees you currently pay.

## Electronic Remittance Advice (ERA)

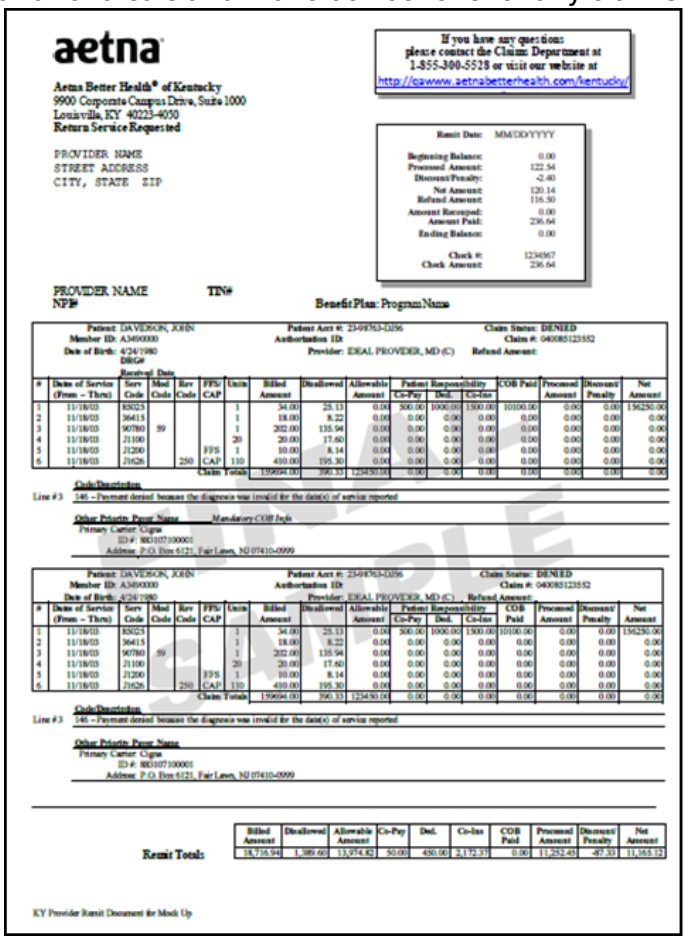
ERA allows providers to auto post payments quickly and efficiently. To enroll for ERA, the provider should call their practice management software (PMS) vendor or hospital information system (HIS) vendor for details.

To enroll in ERA, visit our website at ECHO Health Provider Login

## Remittance Advice

Aetna Better Health generates three weekly remittance advices during a payment cycle that appear as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued.

Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission.



aetna

Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223-4050
Return Service Requested

PROVIDER NAME
STREET ADDRESS
CITY, STATE ZIP

If you have any questions
please contact the Claims Department at
1-855-300-5528 or visit our website at
http://gawww.aetnabetterhealth.com/kentucky/

Remit Date: MM/DD/YYYY

| | |
|---|---|
| Beginning Balance: | 0.00 |
| Processed Amount: | 122.54 |
| Discount/Penalty: | -2.40 |
| Net Amount: | 120.14 |
| Refund Amount: | 116.50 |
| Amount Recouped: | 0.00 |
| Amount Paid: | 236.64 |
| Ending Balance: | 0.00 |
| Check #: | 1234567 |
| Check Amount: | 236.64 |

PROVIDER NAME TIN#
NPI#
Benefit Plan: ProgramName

Patient: DAVIDSON, JOHN
Member ID: A3490000
Date of Birth: 4/24/1980
DRG#
Patient Acct #: 234987653-D256
Authorization ID:
Provider: IDEAL PROVIDER, MD (C)
Claim Status: DENIED
Claim #: 040085123552
Refund Amount:
Received Date

| # | Date of Service (From – Thru) | Serv Code | Mod Code | Rev Code | FFS/ CAP | Units | Billed Amount | Disallowed | Allowable Amount | Patient Responsibility Co-Pay | Ded. | Co-Ins | COB Paid | Processed Amount | Discount/ Penalty | Net Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11/18/03 | 85025 | | | | 1 | 34.00 | 25.13 | 0.00 | 500.00 | 1000.00 | 1500.00 | 10100.00 | 0.00 | 0.00 | 156250.00 |
| 2 | 11/18/03 | 36415 | | | | 1 | 18.00 | 8.22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 3 | 11/18/03 | 90780 | 59 | | | 1 | 202.00 | 135.94 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 4 | 11/18/03 | 21100 | | | | 20 | 20.00 | 17.60 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 5 | 11/18/03 | 21200 | | | FFS | 1 | 10.00 | 8.14 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 6 | 11/18/03 | 21626 | | 250 | CAP | 110 | 410.00 | 195.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | | | | | Claim Totals | 159694.00 | 390.33 | 1234303.66 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

Code/Description
Line #3 146 – Payment denied because the diagnosis was invalid for the date(s) of service reported

Other Priority Payer Name *Mandatory COB Info*
Primary Carrier: Cigna
ID #: 800107100001
Address: P.O. Box 6121, Fair Lawn, NJ 07410-0999

Patient: DAVIDSON, JOHN
Member ID: A3490000
Date of Birth: 4/24/1980
Patient Acct #: 234987653-D256
Authorization ID:
Provider: IDEAL PROVIDER, MD (C)
Claim Status: DENIED
Claim #: 040085123552
Refund Amount:

| # | Date of Service (From – Thru) | Serv Code | Mod Code | Rev Code | FFS/ CAP | Units | Billed Amount | Disallowed | Allowable Amount | Patient Responsibility Co-Pay | Ded. | Co-Ins | COB Paid | Processed Amount | Discount/ Penalty | Net Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11/18/03 | 85025 | | | | 1 | 34.00 | 25.13 | 0.00 | 500.00 | 1000.00 | 1500.00 | 10100.00 | 0.00 | 0.00 | 156250.00 |
| 2 | 11/18/03 | 36415 | | | | 1 | 18.00 | 8.22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 3 | 11/18/03 | 90780 | 59 | | | 1 | 202.00 | 135.94 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 4 | 11/18/03 | 21100 | | | | 20 | 20.00 | 17.60 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 5 | 11/18/03 | 21200 | | | FFS | 1 | 10.00 | 8.14 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 6 | 11/18/03 | 21626 | | 250 | CAP | 110 | 410.00 | 195.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | | | | | Claim Totals | 159694.00 | 390.33 | 1234303.66 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

Code/Description
Line #3 146 – Payment denied because the diagnosis was invalid for the date(s) of service reported

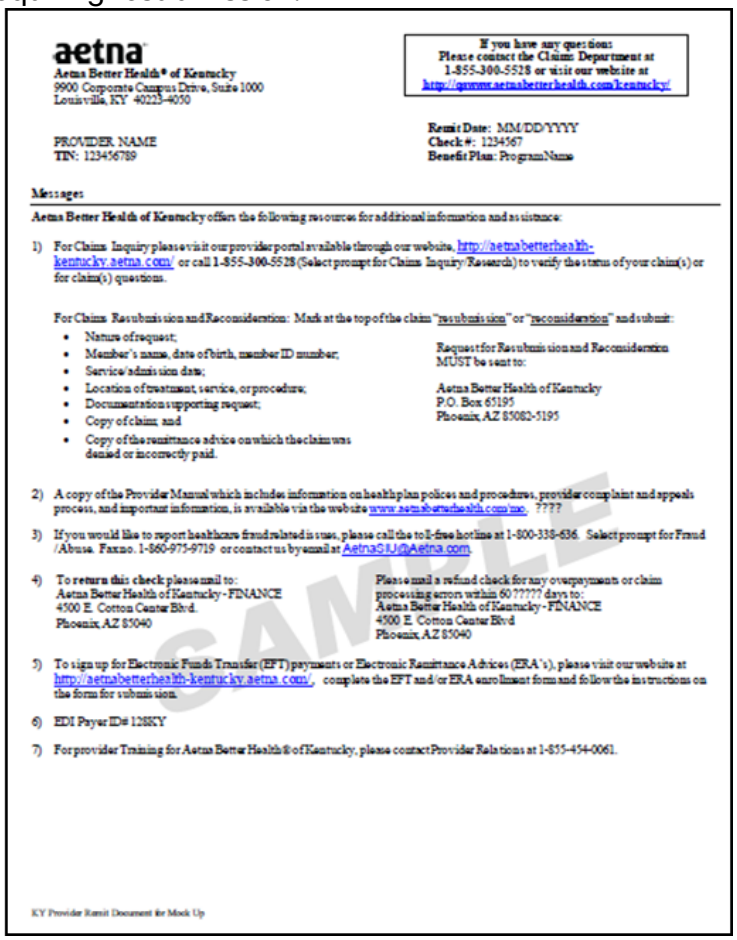
Other Priority Payer Name
Primary Carrier: Cigna
ID #: 800107100001
Address: P.O. Box 6121, Fair Lawn, NJ 07410-0999

Remit Totals

| Billed Amount | Disallowed | Allowable Amount | Co-Pay | Ded. | Co-Ins | COB Paid | Processed Amount | Discount/ Penalty | Net Amount |
|---|---|---|---|---|---|---|---|---|---|
| 18,716.94 | 1,389.60 | 13,974.82 | 50.00 | 450.00 | 2,172.37 | 0.00 | 11,252.45 | -87.33 | 11,165.12 |

KY Provider Remit Document for Mock Up

SAMPLE



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Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223-4050

If you have any questions
Please contact the Claims Department at
1-855-300-5528 or visit our website at
http://gawww.aetnabetterhealth.com/kentucky/

PROVIDER NAME
TIN: 123456789

Remit Date: MM/DD/YYYY
Check #: 1234567
Benefit Plan: ProgramName

Messages

Aetna Better Health of Kentucky offers the following resources for additional information and assistance:

1) For Claims Inquiry please visit our provider portal available through our website, http://aetnabetterhealth-kentucky.aetna.com/ or call 1-855-300-5528 (Select prompt for Claims Inquiry/Research) to verify the status of your claim(s) or for claim(s) questions.

For Claims Resubmission and Reconsideration: Mark at the top of the claim "resubmission" or "reconsideration" and submit:

- Nature of request;
- Member's name, date of birth, member ID number;
- Service/admission date;
- Location of treatment, service, or procedure;
- Documentation supporting request;
- Copy of claim; and
- Copy of the remittance advice on which the claim was denied or incorrectly paid.

Request for Resubmission and Reconsideration MUST be sent to:

Aetna Better Health of Kentucky
P.O. Box 65195
Phoenix, AZ 85082-5195

2) A copy of the Provider Manual which includes information on health plan polices and procedures, provider complaint and appeals process, and important information, is available via the website www.aetnabetterhealth.com/ino. ????

3) If you would like to report healthcare fraud related issues, please call the toll-free hotline at 1-800-338-636. Select prompt for Fraud /Abuse. Fax no. 1-860-975-9719 or contact us by email at AetnaSIU@Aetna.com.

4) To return this check please mail to:
Aetna Better Health of Kentucky - FINANCE
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Please mail a refund check for any overpayments or claim processing errors within 60 ????? days to:
Aetna Better Health of Kentucky - FINANCE
4500 E. Cotton Center Blvd
Phoenix, AZ 85040

5) To sign up for Electronic Funds Transfer (EFT) payments or Electronic Remittance Advices (ERA's), please visit our website at http://aetnabetterhealth-kentucky.aetna.com/, complete the EFT and/or ERA enrollment form and follow the instructions on the form for submission.

6) EDI Payer ID# 128KY

7) For provider Training for Aetna Better Health® of Kentucky, please contact Provider Relations at 1-855-454-0061.

KY Provider Remit Document for Mock Up

SAMPLE

## Program Integrity Program

Aetna Better Health's Special Investigation Unit conducts reviews on a prepayment and post-payment basis. The purpose of this program is to detect, prevent, and correct fraud, waste, and abuse and to facilitate accurate claim payments.

## Prepayment Review Process

Aetna Better Health (or its designee) may utilize the prepayment review process when there is a sustained or high level of payment error or data analysis identifies a problem area related to possible Fraud, Waste and Abuse. Aetna has discretion on when to utilize prepayment review and will consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area.

Prior to placing a provider under prepayment review, Aetna must submit a request in writing to the Division of Health Plan Oversight for approval with copy to the Division of Program Integrity. Department approval is required for any provider prepayment review that Aetna plans to conduct.

Once Aetna receives Department approval, Aetna will send notice to the provider that they are being placed on prepayment review in writing through multiple modes of communication at least (2) days before the date a prepayment review is started. The provider will be notified of the below.

- The specific reason for the review.
- The description of the specific documentation needed for the review and how to submit the documentation.
- The timeframe for returning the documentation.
- Contact information if there are questions related to the prepayment review.
- Information on how the provider may request removal of a prepayment review.

Providers have (45) days from the date the claim is submitted to provide documents in support of claims under prepayment review. Aetna will review provider documentation within (30) days of receiving the documents to determine whether the claim should be paid. Claims under prepayment review are not subject to prompt payment or timely filing requirements. Aetna will deny a claim when the submitted documentation lacks evidence to support the service or code.

## Post-Payment Review Process

Aetna Better Health (or its designee) conducts reviews of healthcare professionals' records related to services rendered to Aetna Better Health members. During these reviews, providers and/or facilities are asked to allow Aetna Better Health access to medical records and billing documents that support the charges billed. Aetna Better Health's reviews look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the healthcare industry, including the Medicaid programs.

Examples include, but are not limited to:

- Excessive billed charges or selection of the wrong code(s) for services or supplies
- Billing for items or services that should not have been or were not provided based on documentation supplied

- Unit errors, duplicate charges, and redundant charges
- Insufficient documentation in the medical record to support the charges billed
- Experimental and investigational items billed
- Lack of medical necessity to support services or days billed
- Uncovered services per the member's benefit plan, Aetna policies, Medicare policies, or Medicaid policies
- Lack of objective clinical information in the medical record to support condition for which services are billed
- Items not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.

These reviews also confirm that:

- The most appropriate and cost-effective supplies were provided.
- The records and/or documentation substantiate the setting or level of service that was provided to the patient.

### Reviews and Records Requests

Aetna Better Health of Kentucky may conduct reviews of claims as required or allowed by applicable law and may request medical records, itemized bills, invoices, or other substantiating documentation to support the charges billed. Healthcare professionals are asked to send copies of requested documentation within thirty (30) days of the request or within the appropriate federal and/or state guidelines.

### Records Submission

Details on how to submit records are included within the notification letter that will be sent at the first stage of the review process.

### Outcome

If Aetna Better Health of Kentucky or its designee determines that a coding and/or payment adjustment is applicable, the healthcare professional will receive the appropriate claim adjudication, an explanation of remittance (EOR), and a findings letter. Physicians and other healthcare professionals may have the right to dispute results of reviews as stated in the Aetna Grievance and Appeal Process ("G&A Process"). Those who are not in agreement with the explanation or findings may refer to the G&A Process for details.

### Collection Advice/Remittance

When a claim has been adjusted, which results in a negative balance [for longer than thirty (30) days], you will receive collection advice once per month. You should receive the claims detail that created the negative balance, along with any offsetting claims, with the monthly collection advice.

If your office does not have enough claim volume to clear this negative balance within a month, please refund the overpayments. The collection advice summary indicates the amount of refund we are requesting. Once the refund has been processed, a check or electronic fund transfer (EFT) will be issued for any positive claims that are being held.
Please make your refund check payable to Aetna Better Health and mail to the following address:

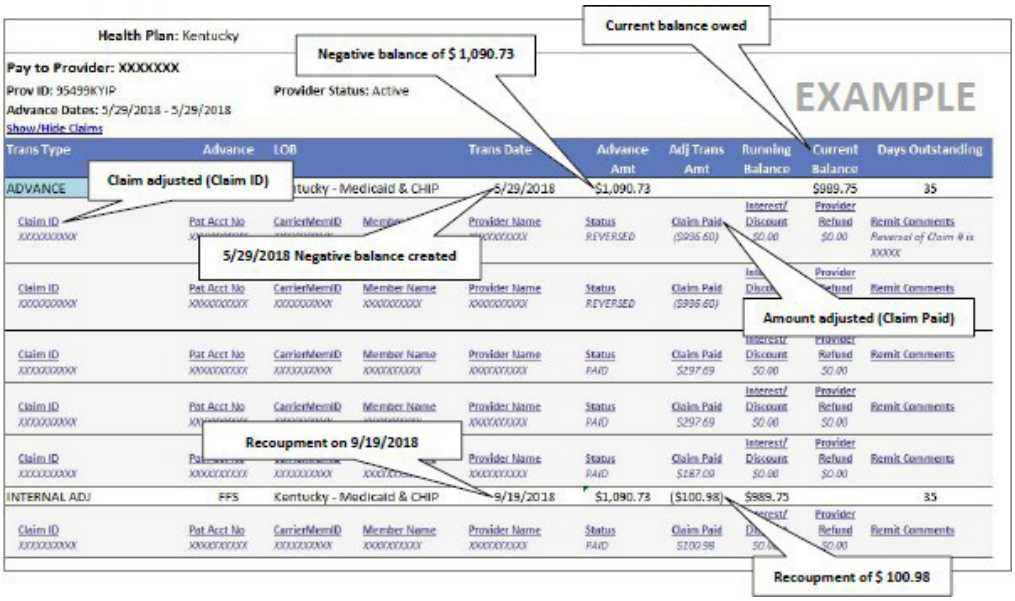
Aetna Better Health of Kentucky
Attn: Finance
P. O. Box 842605
Dallas, TX 75284-2605

In the example:

- 5/29/2018 negative balance created
- Claim adjusted (Claim ID)
- Amount adjusted (Claim Paid)
- Final negative balance of $1,090.73 (sum of original amount due by provider)

In addition:

- recoupment of $100.98 on 9/19/18
- Current balance owed (original amount due by provider offset by claims processed)




If you have questions about the reversed claims, please contact Claims Customer Service at **1-855-300-5528**.

## Recoveries

Aetna Better Health reserves the right to request recovery of overpaid claims up to twenty-four (24) months after the first remittance advice date, whether the initial claim paid or denied except in cases of fraud or misrepresentation where the time may be longer.

In the event Aetna Better Health determines that a provider was overpaid, Aetna Better Health shall provide written or electronic notice to the provider with the amount of the overpayment, a member identifier, date(s) of service, Aetna Better Health's reference number for the claim, and the basis for determining that an overpayment exists. If a refund is not received within thirty (30) days of the postmark date/electronic delivery date of our notice, or if the provider has not disputed the overpayment recovery request, the amount of the overpayment will be recouped from future payments through offset.

Providers can send a notice of disagreement with the overpayment recovery request within thirty(30) days from the postmark date/electronic delivery date and submit additional relevant information to Aetna Better Health. In such an instance, Aetna Better Health shall not proceed with the recoupment until the dispute is resolved. Disputes shall be resolved within thirty (30) calendar days of receipt through Aetna Better Health's provider appeals process outlined in this Provider Manual.

If you identify an overpayment, contact Claims Customer Service at 1-855-300-5528 and request an adjustment to correct the overpayment, or send a check in the amount of the overpayment with a copy of the remittance advice identifying the claim that was overpaid to:

Aetna Better Health of Kentucky
Attn: Finance
P. O. Box 842605
Dallas, TX 75284-2605

In accordance with the Kentucky law, within forty-eight (48) hours of receipt of an electronically filed original or corrected claim, Aetna Better Health will send electronic acknowledgement of the date of receipt, or status notice indicating the reason for rejection (i.e., what information might be missing, what errors might exist on the claim, or why the claim is not otherwise clean). Except for claims involving organ transplants Aetna Better Health shall, within thirty (30) days of receipt of a claim or additional information, process for payment the undisputed portion of the claim, denying all or part of the claim, or send notice for additional information. For claims involving organ transplants, Aetna Better Health shall, within sixty (60) days of receipt, process for payment the undisputed portion of the claim, denying all or part of the claim, or send notice for additional information.

Clean claims with all required information that are not adjudicated (paid, denied, zero paid) by Aetna Better Health within the specified timeframes of receipt shall be paid with interest, in accordance with Commonwealth of Kentucky statute.

Aetna Better Health will process clean claims submitted by a provider within thirty (30) days of receipt. Claims that are not considered clean, as defined in this Provider Manual, may be denied.

### On-site Meeting

Providers have the opportunity for an in-person meeting with their assigned Network Manager on any clean claim under KRS 304.17A-700 to 304.17A-730. This includes clean claims that are unpaid for forty-five (45) days or more with individual or aggregate amounts exceeding $2,500.00.

### Claim Specific Requirements

In the following instances, please note the additional requirements that will facilitate payment of the claim.

### Anesthesia Start/Stop Times

American Society of Anesthesia codes must be submitted with the appropriate start and stop times, clearly noted on the claim. This information should be provided in Section 24D of the CMS 1500 form. Start and stop times handwritten on a typed claim form should be initialed.

### Assistant Surgeon

Assistant surgeon charges are indicated on a provider's claim (CMS 1500 form, block 24D) with an 80, 81, or 82 modifiers. Modifier 81 is not reimbursable per Kentucky Medicaid. Aetna Better Health will reimburse modifier AS for only Physician and ARPN practitioners.

### Bilateral Procedures

Bilateral procedures are defined as those performed on two (2) sides of the same surgical area. Bilateral procedures should be submitted with one (1) unit and include a 50 modifier. Claims for bilateral procedures noted with a 50 modifier and containing more than one (1) unit will be split onto two (2) lines for correct processing.

### Modifiers

A modifier can be added to a HCPCS or CPT code to describe a unique service or procedure that was performed in the medical setting. The modifier can be reported by adding a two-digit number (or alphabetic characters) after the appropriate HCPCS or CPT code. Please refer to the AMA HCPCS Level I and II coding guides for a complete list of available modifiers.

## Immunizations

Through the Vaccines for Children (VFC) program, federally provided vaccine serums are available at no charge to public and private providers for eligible children ages newborn through 18 years. Children that meet at least one (1) of the following criteria are eligible for vaccines through the VFC program:

- Kentucky Medicaid enrolled: the child is enrolled in the Kentucky Medicaid program.
- Uninsured: a child has no health insurance coverage.
- Native American/Alaska Native: those children as defined in the Indian Health Care Improvement Act.
- Underinsured: the child has some type of health insurance, but plan benefits do not include vaccinations.

Kentucky Medicaid requires providers who administer VFC immunizations to qualified Kentucky Medicaid eligible children to enroll in the VFC program. The Cabinet for Health and Family Services (CHFS) administers the VFC program. To enroll, providers may contact their CHFS immunization program field staff representative for their area. If you are interested in enrolling, a contact list of field staff representatives may be found at www.chfs.ky.gov/dph/epi/Health+Care+Professionals.htm**.**

Per the Center for Disease Control (CDC): To ensure that the correct supply of vaccine is used, participating VFC providers must verify member eligibility and status codes to distinguish whether the child is Medicaid (P1, P2, P3, P5, or P6) or KCHIP (P7) at every visit or encounter prior to rendering services. Eligibility and status code are confirmed by accessing KYHealthNet at https://public.kymmis.com.

Per current billing instructions, vaccines will be paid by the following:

- For patients under age 19, bill Medicaid using the administration CPT and the vaccine CPT. If the vaccine was acquired from the Vaccines for Children (VFC) program, bill modifier SL with the vaccine and administration CPT codes. If not, bill the vaccine CPT without modifier SL.
- For patients 19 and older, bill KY Medicaid using the administration CPT and the vaccine CPT. Do not use modifier SL.

## Smoking Cessation

Smoking cessation counseling should be performed for patients with nicotine dependence, issues with nicotine toxicity, or a personal history of nicotine dependence. Evaluation and management services are payable on the same day as smoking and tobacco-use cessation counseling services only when medically necessary, as indicated by the appropriate modifier.

## Clinical Claims Editing

Aetna Better Health uses claims editing software, which follows National Correct Coding Initiative (NCCI), AMA, and CMS guidelines. Claim edits are designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Claim editing applications review claims submitted with CPT-4 HCPCS Level 1 and 2 codes to analyze the appropriate set of procedures for reimbursement.

The major areas reviewed as part of claim editing include:

- **CPT Unbundling** – Procedural unbundling occurs when two or more procedure codes are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. When this occurs, the component procedures will be denied and

re-bundled to pay the comprehensive procedure.
    - If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and re-bundled to the comprehensive code.
    - If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied, and the comprehensive code will be added to the claim for payment.
- **Incidental procedures** – Procedures that are performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.
- **Mutually-exclusive procedures** – Two (2) or more procedures that are billed, by medical practice standards, should not be performed or billed for the same member on the same date of service.
- **Duplicate procedures** – Procedures that are billed more than once on a date of service.
- **Assistant surgeon utilization** – Determination of reimbursement and coverage.
- **Evaluation and management service billing** – Review the billing for services in conjunction with procedures performed.
- **Emergency room evaluation and management services** – Review the billing of high-level evaluation and management services against ACEP guidelines.
- **NCCI Medically Unlikely Edits (MUE) reduction** – For claims where the number of units exceed MUE limits for Medicaid, reductions will be applied to percentage of billed contracts.

### Multiple Surgical Procedures

CMS has developed payment guidelines when multiple procedures are billed together on the same date of service. Aetna Better Health will apply standard multiple procedure reductions when a provider performs and bills two or more surgical procedures for the same date of service. The first procedure is paid at 100%, the second procedure is reimbursed at 50%, and then, according to Aetna Better Health contracts, the third and all subsequent procedures are reimbursed at 50%. Surgical procedures are ranked by Relative Value Unit (RVU); the highest RVU procedure will be paid at 100%. Procedures can be done bilaterally. A bilateral procedure is reimbursed (for both sides with a unit of 1 and a -50 modifier) at 150%. There are some procedures identified by CMS that are not subject to multiple procedure reduction edits. Our editing software will remove the -51 modifier when it is billed on these procedures so that the provider can obtain the correct reimbursement at 100%.

- A second example of a multiple procedure reduction edit is when a provider bills for multiple endoscopy procedures for the same member on the same date of service. Aetna Better Health follows the CMS guidelines for reimbursement of these procedures. The lesser valued endoscopy codes will be paid at the difference between its allowed value and the base endoscopy allowed value. Multiple families of endoscopy procedures will be first calculated at their family reduction rate, and then receive the secondary reduction of 100-50-50.
- Multiple radiology procedures billed for the same member and same date of service will also follow CMS guidelines for reimbursement. The imaging procedure with the highest technical component (TC) will be reimbursed at 100%, and the technical component for all secondary procedures is reduced by 50%. This reduction applies only to the radiology procedures with the -TC modifier.
- Multiple procedure reduction edits are particularly sensitive if the episode of care for the member is billed on more than one claim. Out-of-sequence claims can cause adjustments and incorrect payments as the entire episode cannot be correctly evaluated.

When reviewing a remittance advice, any CPT-4 HCPCS Level 1 and 2 code that has been changed or denied due to claims editing will be noted by the appropriate disposition code.

## Submission of Itemized Billing Statements

Aetna Better Health may require providers to submit an itemized billing statement in addition to the original claim. If an itemized billing statement is required and not supplied, the claim will be denied until one is received. When submitting by paper, providers should send the requested itemized billing statement to the claims P.O. Box with the correct type of bill.

If the charges on the itemized bill are less than the billed charges on the original claim, or we deny if charges don't match the claim will be denied. All itemized charges must be billed with corresponding revenue codes. Itemized bills may be further subject to review prior to payment. This review will examine the claim for eligible charges prior to payment.

All claims, including DRG claims with outliers, that have expected reimbursement of $50,000 and above require itemized bills as part of our audit process. Claims submitted without the itemized bills will be denied. The claims will deny as "Itemized Bill Missing." The claim will need to be resubmitted with the itemized bill before the claim is reviewed.

Paper claims can be submitted to:

Aetna Better Health of Kentucky
P.O. Box 982969
El Paso, TX 79998-2969

## Electronic visit verification (EVV)

EVV is an electronic system providers use to record information when delivering Personal Care Services (PCS), which includes certain in-home or community-based 1915(c) Home and Community Based Services (HCBS) or Home Health Care Services (HHCS). The use of EVV is a requirement of the Cures Act passed by Congress in 2016. EVV must electronically verify six aspects of service delivery: the date, location and type of service, the individual providing the service, the individual receiving the service and the start and end times of the service.

EVV offers several benefits such as eliminating the need for paper documentation, creating flexibility in scheduling and delivering services, improved monitoring of participant health, safety and welfare and reduction in potential Medicaid fraud, waste and abuse. MCOs and DMS have been in a "soft launch" period since late 2023 to allow providers time to adopt DMS's EVV guidelines and begin submitting EVV visit data.

The following provider types and service codes are required to use EVV when delivering in-home HHCS to Medicaid participants. Provider Types Impacted Model II Waiver (MIIW) NOTE: Medicaid FFS Only Home Health Services (HH) Private Duty Nursing (PDN) HH or PDN services provided through a Managed Care Organization

Services that Require EVV 410 - Respiratory Therapist - MIIW 552 - Registered Nurse - MIIW 559 - Licensed Practical Nurse - MIIW 420 - Physical Therapy - Home Health 430 - Occupational Therapy - Home Health 440 - Speech Therapy - Home Health 550 - Skilled Nursing - Home Health 560 - Medical

Social Services - Home Health 570 - Home Health Aide - Home Health T1000 - Private Duty / Independent Nursing - Private Duty Nursing Providers have two options for using EVV.

DMS has selected Therap Services LLC to launch EVV HHCS in Kentucky. Therap Services LLC is a national EVV company that has launched EVV in multiple states. Providers can sign up and receive training on the Therap solution and can use it free of charge. DMS also allows providers to use their own EVV systems. Those systems will not be paid for by DMS and will be the responsibility of the providers using them. Provider EVV systems must meet the requirements of the 21st Century Cures Act and integrate with Therap to allow DMS to view visit information and conduct quality assurance activities. Providers who have questions can reach out to 1915cWaiverHelpDesk@ky.gov or call 844-784-5614. Providers may also communicate directly with Therap via email at kysupport@therapservices.net

## Legal Owner of Tax Identification Number (TIN)

Each provider's legal name and billing address are loaded in the Aetna Better Health provider database from the information on your submitted W-9 form. If there is a change to the provider's name, address, TIN, or legal owner of the TIN, you must submit an updated W-9 form to your Network Manager. Your submission should include the effective date of the change.

Aetna Better Health should receive the change at least sixty (60) days prior to the effective date of the change. The legal owner of the TIN as listed on line 1 of the W-9 should be listed in Box 33, Line 1 of the CMS 1500 form, or Block 2 of the UB-04 form. If a claim is submitted with conflicting information in Box 33, Line 1 of the CMS 1500 form, or Block 2 of the UB-04, the claim will be denied by Aetna Better Health.

It is important for Aetna Better Health to comply with the IRS requirements to assure all claims are processed under the legal name. This will also allow for accurate processing of 1099 forms and avoid mandatory IRS tax withholding on claim payments. If you have questions regarding your legal name and address information in our system, please contact Network Relations at **1-855-300-5528**.

## Caution When Using your Social Security Number (SSN) in Lieu of TIN

Provider Identification numbers (i.e., Tax Identification Number [TIN], Federal Tax Identification Number [FTIN], Employer Identification Number [EIN]) containing your personal social security number (SSN) may present unnecessary risks to your identity.

Please request new identification numbers if you are using your personal SSN. This will ensure your SSN is not exposed over the course of standard business practices and protect yourself from unnecessary harm.

To request new provider identification numbers, please visit www.irs.gov for more information or contact your local Internal Revenue Service (IRS) office.

# Provider Appeals and Grievances

At Aetna Better Health of Kentucky, we care about our providers. There may be times, however, when a provider will need to file an appeal or a grievance. Both complaints and appeals can be clinical or administrative. Clinical cases are about decisions we make based in whole or in part on medical criteria. This includes decisions based on medical necessity and policies on cosmetic procedures. Treatments or procedures ruled as experimental or investigational are included as well. You have a right to request and receive a written copy of the criteria, policy, or procedure we used to review your case if it was about a clinical decision.

## Appeal Process for Providers

An appeal is the provider's right to have adverse determinations we made reviewed, pursuant to 907 KAR 17:015. An appeal occurs when the provider (a) has a claim for reimbursement denied or not acted upon within a reasonable time; or (b) has a contractual dispute related to its provider agreement with Aetna Better Health. Remember that a Medicaid member can't be held liable for services or claims we've denied payment on.

Appeals and any relevant supporting documentation should be sent to the address below.

**Aetna Better Health of Kentucky**
**Attn: KY Appeals & Grievances**
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

When you submit a written appeal, include a letter about the details of the appeal. You should also include documentation that supports your appeal. We must receive your appeal within one (1) year of the incident, remit date or date of notice of action that caused the appeal. We will respond to your appeal in writing within thirty (30) calendar days of when we receive it. The response will be sent by mail.

If you are filing an appeal on the member's behalf, it will be processed like a member appeal. Except in the case of an emergency, you must submit the member's written authorization allowing you to submit the appeal for the member. You should send this authorization with the appeal. The appeal will be handled according to the member appeal process. You must send your member appeal within sixty (60) days of the date of the notice of adverse benefit determination denying, suspending, reducing, or terminating the requested service or equipment.

## Expedited Requests

When acting on a member's behalf, you may request an expedited appeal for circumstances when waiting the usual period for a decision would seriously jeopardize (a) the life or health of a member or in the case of a pregnant member, the member's unborn child; or (b) a member's ability to attain, maintain, or regain maximum function.

**You may request an expedited appeal by calling us at 1-855-300-5528, ask for Member Services. If you need a status of an Appeal or Grievance, please call 1-855-300-5528, press *, then option 2.**

A written appeal isn't required in this case. If your request meets the above criteria, we will make a decision within 72 hours or earlier, as the member's physical or mental health requires. If your request to expedite the case is not approved, it will be processed in the normal time frame. We will make all reasonable attempts to notify the member and their representative (if applicable) of when the final decision can be expected. In these cases, written consent from the member will be required before the appeal is processed.

**All after-hour expedited requests can be sent to the Appeals fax line at 1-855-454-5585.**

## Conduct of the Review

While you can appeal or file a complaint about a complaint outcome, you have the choice to file an appeal without filing a complaint first. We must have a written letter from you to document your request for an appeal. You have one year from the incident, remit date, or date of our last denial letter to get your appeal to us. Send your appeal and supporting information to the address below:

Aetna Better Health of Kentucky
Attn: KY Appeals & Grievances
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

We use different staff to review appeals, based on the issue. For example, a Medical Director reviews clinical decisions, and senior management members, along with at least one Medical Director, review administrative issues.

## Resolution of the Appeal

Within five (5) business days of the day we receive your appeal we will send you a letter letting you know it's been received. Within thirty (30) calendar days from the day, we receive your appeal, we will send you a decision letter explaining what we have decided about your appeal. This letter will have the credentials of the person or people involved in the appeal review. If requested, responses will be sent via fax if a fax number is provided. In some cases, we may extend the appeal response time by fourteen (14) days. We will only extend the case if it is beneficial to you. If the extra time we use for investigating the appeal is not acceptable to you, you have the right to file a grievance to dispute the extra days.

## Review Decisions

We review administrative grievances and appeals with appropriate health plan personnel based on the situation. We will send you a resolution letter that includes the credentials of the professional who reviewed your grievance or appeal.
Clinical grievances and appeals are reviewed by health professionals who:

- Hold an active, unrestricted license to practice medicine or in a health profession
- Are in the same profession or in a similar specialty as typically manages the medical condition, procedure, or treatment at issue; and
- Are neither an individual involved in the original review or decision, nor the subordinate of such individual

## Provider External Review

If you don't agree with our decision on your appeal, the state allows you to have a third-party review your case, pursuant to 907 KAR 17:035.

Provider Requests pursuant to 907 KAR 17:035 will only be considered for dates of service December 1, 2016 and forward.

An external review is your right to have our decision reviewed by an outside reviewer. The reviewer is chosen by the State of Kentucky. A review may be requested when we issue an adverse decision on an appeal you submit regarding (a) a claim involving a medical necessity determination; (b) a claim involving whether the given service is covered by the Medicaid program; or (c) a claim involving whether the provider followed the MCO requirements of the covered service.
You can send your request electronically, by fax or by postal mail. If you wish to send your request by mail, send your request and the required documentation (listed below) to the address below.

**Aetna Better Health of Kentucky**
**Attn: KY Appeals & Grievances**
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

If you wish to fax your request, our fax number is 1-844-359-6670. To submit your request electronically, email AetnaExternalReview@aetna.com.

A request for an external review must be received within sixty (60) calendar days of the postmark date on the envelope containing our decision or the electronic receipt date, if your decision was sent by fax or email.

When you submit a request for an external review, include a completed Provider External Review Cover Page and a letter that:

- Clearly states each specific issue and dispute you have with our decision
- Clearly states the reason you believe our decision is wrong
- Give the name, mailing address, email address, fax and telephone number of your designated contact person who may be contacted about your request

We'll let you know we received your request by sending your designated contact person a letter within five (5) business days of the day we received your letter. We'll notify the Department for Medicaid Services (DMS) and the member involved of your request within five (5) business days as well.

When DMS receives your request, they'll assign your request to a reviewer. They'll contact you with details, including the name of the reviewer, the location and date of the review, and more information on the review process.

If, after you have requested an external review, the member involved files a request for an administrative hearing pursuant to 907 KAR 17:010 regarding the same claim, your external review will be held in abeyance until the member's appeal has been fully adjudicated.

We will let you know we received your request by sending you a letter within five (5) business days of the

day we received your letter. We will notify the Department for Medicaid Services, and the member involved of your request within five (5) business days as well.

A provider who has exhausted the internal appeal process shall have a right to appeal a final denial, in whole or in part, to an external independent third party in accordance with applicable state laws and regulations. A provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation and KRS Chapter 13B. If the provider prevails in the external appeal, we will comply with the Final Order within sixty (60) days unless the Final Order designates a different timeframe.

## Provider Grievances

A grievance is a complaint about an action we have taken regarding a member's health plan benefits and is the formal process for resolving provider dissatisfaction not related to an appeal. **Grievances can be made by calling 1-855-300-5528, ask for Member Services. If you need a status of an Appeal or Grievance, please call 1-855-300-5528, press *, then option 2. You can call us from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday.** Be sure to tell us you are filing a grievance.

When you call us about a complaint, remember that for us to review your concern you may need to provide us with supporting information. We might need things like medical records that help to explain your concern. You can also write to us about the problem at the address below.

**Aetna Better Health of Kentucky**
**Attn: KY Appeals & Grievances**
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

When you send us a letter about your problem, include the details of the issue. You can also send us any documentation that helps to explain the issue. You must send us your letter within one (1) year of the date of the service that is involved. When we receive your letter, we'll review it. Within five (5) business days, we'll send you a letter acknowledging that we received it.

We will respond to all grievances within thirty (30) calendar days of receipt of the grievance. Our response will be in writing. In some cases, a grievance will need to be extended for an additional fourteen (14) days. If the response time is extended, we will send you a notice. If requested, responses will be sent via fax if a fax number is provided. Otherwise, you will receive the response by mail.

**Provider grievances are handled according to the guidelines established in 907 KAR 17:015.**

# Fraud, Waste and Abuse

## Fraud, Waste, and Abuse Guidelines

Aetna Better Health is a Kentucky Medicaid Managed Care Organization and, as such, is bound by all federal and state anti-fraud and abuse programs. Aetna Better Health must report any potential fraud or abuse by our providers and members. We are bound contractually by the Commonwealth to report these occurrences and must investigate any fraudulent or abusive behavior meeting the following definition:

### Kentucky Medicaid Managed Care Fraud Definition

Any type of intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law.

### Kentucky Medicaid Managed Care Waste Definition

Waste means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources. In order to meet this definition, the act does not have to be intentional, and the actor does not have to specifically intend for waste to occur.

### Kentucky Medicaid Managed Care Abuse Definition

With reference to a health care provider, practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the Medicaid program established pursuant to this chapter, or that result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary costs to the Medicaid program. It should be noted that Kentucky Medicaid funds paid to an MCO, then passed to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

## Program Description

Aetna Better Health has a comprehensive fraud and abuse program for both providers and members. Within our program, fraud and abuse prevention, detection, reporting, reviewing, and corrective actions are our main goals. Much of the detection process comes from providers because they are in the best position to see characteristics of fraud, which leads to the minimization of fraud loss. Organizations suffer tremendous costs as a result of fraud and abuse. With the basic understanding of fraud and abuse along with some common examples, it will be easier to detect any fraudulent activity routine.

Some common examples of member fraud are:

- Lending, selling, or giving a health plan ID card to someone else
- Getting similar treatments from different doctors
- Getting medicines that are not necessary
- Going to an emergency room if you know it is not an emergency
- Using someone else's Social Security number or member ID number
- Receiving money or gifts in exchange for having medical services

Some common examples of provider fraud are:

- Falsifying medical records
- Prescribing more medication than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not rendered
- Billing for items not provided
- Billing for professional services when a medical professional did not perform the service

By understanding the common acts of fraud and abuse, we can all work together to try and eliminate the effects of fraudulent and abusive behaviors.

## Reporting Suspected Fraud and Abuse

Suspected fraud, waste, or abuse can be reported in the following ways:

- By phone to the confidential Aetna Better Health of Kentucky Fraud Waste and Abuse Hotline at **1-855-300-5528**
- By phone to our confidential Aetna Special Investigations Unit at **1-800-338-6361.**
- Through the Aetna Better Health of Kentucky website: https://www.aetnabetterhealth.com/kentucky/fraud-abuse

Suspected Provider fraud, waste, or abuse can also be reported to the Attorney General's office. To report suspected provider fraud, call the Medicaid Fraud and Abuse Hotline at ***1-877-ABUSE TIP*** **(1-877-228-7384)** or complete the online KY Medicaid Fraud and Abuse Complaint Form: https://secure.kentucky.gov/FormServices/AttorneyGeneral/MedicaidFraudandAbuse

If you know or suspect that a recipient is defrauding or abusing the Medicaid program, or another assistance program, please notify the Office of the Inspector General at the Cabinet for Health and Family Services. To make a report, please call the **Welfare and Medicaid Fraud Hotline at 1-800-372-2970**.

There are several relevant laws that apply to fraud, waste, and abuse:

**Federal Deficit Reduction Act of 2005 (DRA)**

Congress passed the Federal Deficit Reduction Act of 2005 (DRA). Aetna Better Health, as an entity which receives or makes payments under a State Plan approved under Title XIX, or under any waiver of such plan, totaling at least $5,000,000 annually, is required by Section 6032 of the DRA to establish and disseminate written policies to employees and contractors. These policies must include detailed information about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C. §§ 3801 et seq., and applicable state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, "False Claims Acts").

**The Federal False Claims Act (FCA)** (31 U.S.C. §§ 3729-3733) was created to combat fraud and abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when health care providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval

- Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

"Knowingly" means that a person, with respect to information

1. Has actual knowledge of the information
2. Acts in deliberate ignorance of the truth or falsity of the information
3. Acts in reckless disregard of the truth or falsity of the information
4.

**Anti-Kickback Statute**
The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal healthcare program. Remuneration includes anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.

**Self-Referral Prohibition Statute (Stark Law)**
Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship unless an exception applies.

**The Federal Program Fraud Civil Remedies Act** (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims' penalty is to be adjusted periodically for inflation in accordance with a federal formula.

CMS has defined "contractors" as "any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Kentucky Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. CMS clarified that participating providers are to be considered "contractors" for the purpose of the DRA.

Therefore, we are required to inform you of Aetna's Employee and Contractor False Claims Act Education materials. These materials can be easily accessed at the Document Library link on AetnaBetterHealth.com/Kentucky, or upon request to your Network Relations Manager. In addition, more information about the DRA and these requirements are available for your review on the CMS website www.cms.hhs.gov.

## State and Federal Program Requirements and Services Communicable Disease Reporting

Providers are required to comply with any applicable communicable disease reporting requirements.

## Physician Incentive Program (PIP) Regulations

The federal Physician Incentive Program regulation is designed to protect beneficiaries enrolled in Medicare and Medicaid Managed Care Organizations by placing certain limitations on provider incentive programs that could influence a physician's care decisions.

On an annual basis and in compliance with this federal regulation, Aetna Better Health must disclose

provider incentive programs to CMS and the Cabinet. The information to be disclosed shall include the following:

Effective date of the provider incentive program

- Type of incentive arrangement
- Amount and type of stop-loss protection
- Member panel size
- Description of the method, if pooled
- For capitation arrangements, provide the amount of capitation payment broken down by percentage for primary care, referral, and other services
- Computations of significant financial risk
- Whether the health plan does not have a provider incentive program
- Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the provider incentive program

## Overview of the Provider Incentive Program (PIP) Regulation

Provider incentive programs (PIPs) are compensation arrangements that may exist between managed care organizations (MCOs) and provider or provider groups, or between provider groups and individual providers. PIPs may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled in an MCO. Federal regulations protect beneficiaries enrolled in Medicaid MCOs by placing certain limitations on PIPs that could influence a provider's care decisions. If you are a provider or a provider group, however, you should still be informed of the following regarding your own relationships with other providers and provider groups.

### To Whom Does This Section Apply?

If you are a provider, a provider in a provider group, or a provider who is part of an IPA or other network arrangement (such as a behavioral health provider contracted through the Aetna Better Health behavioral health network), this section will apply to you.

### What Information is Required to be Disclosed/Reported?

On an annual basis, and in compliance with federal regulations, Aetna Better Health must disclose to the Centers for Medicare and Medicaid Services (CMS) and CHFS any PIPs that it has established, or that its contracted providers have in place. This disclosure includes whether any risk is transferred (i) to the provider or provider group by Aetna Better Health, or (ii) to a provider or provider group by an IPA or another intermediate entity. If yes, by what method?

- Whether any risk is transferred (i) to the provider or provider group by Aetna Better Health, or (ii) to a provider or provider group by an IPA or another intermediate entity for referral services.
- What percent of total potential payment to the provider/provider group is at risk for referrals?
- What is the number of members included in the same risk arrangement if the number of members is 25,000 or fewer; what is the type and amount of stop-loss protection insurance?
- Whether the PIP puts providers/provider groups at "substantial financial risk."
- If there is "substantial financial risk," what is the amount of stop-loss protection required and how are the survey requirements met?

### How Can Providers and Subcontractors Cooperate With Aetna Better Health?

Providers shall cooperate with Aetna Better Health with respect to, and shall comply with, the PIP requirements including, but not limited to, the following:

- Upon request, providers/provider groups will submit to Aetna Better Health all data necessary for Aetna Better Health to meet its PIP disclosure and reporting obligations in accordance with federal law and the Kentucky Medicaid contract. Providers/provider groups shall certify, in writing, the completeness, truthfulness, and accuracy of all such data.
- If any providers/provider groups are at "substantial financial risk" such providers/provider groups agree to obtain stop-loss protection as required by the federal regulations.
- Providers/provider groups shall cooperate with Aetna Better Health regarding the obligation of Aetna Better Health to conduct surveys of members in instances where a provider/provider group has indicated that it is at "substantial financial risk."

**What Payments are Prohibited?**
PIPs may not include any direct or indirect payments to providers/provider groups as an inducement to limit or reduce necessary services furnished to an Aetna Better Health member. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. This prohibition does not preclude Aetna Better Health from encouraging its contracted providers to authorize only those services that are medically necessary. In addition, PIPs cannot legitimately operate unless stop-loss protections, enrollee survey, and disclosure requirements of the PIP regulation are satisfied, as discussed in greater detail below.

**What Information Must Be Reported to CMS and The Cabinet by Aetna Better Health?**
The disclosure requirements apply not only to Aetna Better Health's direct contracting arrangements with providers, but to its subcontracting arrangements as well. In general, MCOs must provide to CMS information concerning their PIPs as may be requested by CMS. In addition, MCOs that contract with a provider group that places the individual provider members at substantial financial risk (SFR) for services they do not furnish must disclose any incentive plan between the provider group and its individual providers that bases compensation to the provider on the use or cost of services furnished to Medicare beneficiaries or Kentucky Medicaid recipients.

Finally, when an MCO contracts with an intermediate entity such as an individual practice association (IPA) that, in turn, contracts with one or more provider groups and a provider hospital organization (PHO), the MCO must disclose to CMS any incentive plans between the intermediate entity and a provider or provider group that bases compensation on the use or cost of services furnished to Medicare beneficiaries or Kentucky Medicaid recipients.

**What Information Must be Reported to Aetna Better Health Members?**
For Medicare or Kentucky Medicaid beneficiaries who request it, contracting MCOs must provide information indicating (i) whether the MCO or any of its contractors or subcontractors uses a PIP that affects the use of referral services, (ii) the type of incentive arrangement(s) used, and (iii) whether stop- loss protection is provided. If the MCO is required to conduct a survey, it must also provide beneficiary requestors with a summary of survey results.

**What is Substantial Financial Risk (SFR)?**
SFR occurs when the incentive arrangement places the provider or provider group at risk for amounts beyond the risk threshold, which is the maximum risk, if the risk is based on the use or costs of referral

services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider's or group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

**What Happens when Substantial Financial Risk Exists?**

In sum, if a PIP puts a provider or provider group at SFR for referral services, Aetna Better Health must survey current and previously enrolled members to assess member access to and satisfaction with the quality of services. In addition, adequate and appropriate stop-loss protections must be in place to protect providers and/or provider groups to whom SFR has been transferred.

Failure to comply with the PIP rule may result in application of intermediate sanctions, or imposition of civil money penalties, as described in 42 CFR §417.500 and 42 CFR § 434.67. CMS may also withhold Federal Financial Participation from the state if the state or an MCO fails to fulfill State Plan or contract requirements, respectively.

# Behavioral Health

## Covered Behavioral Health Services

Aetna Better Health of Kentucky ensures the provision of all medically necessary behavioral health services for members and covers services for mental health and substance use disorders. These services include inpatient mental health and substance use services, outpatient mental health and substance use services (including intensive home services), intensive outpatient, substance use residential, mobile crisis, residential crisis stabilization, assertive community treatment, peer support services, Community Mental Health Center services, Psychiatric Residential Treatment Facility (PRTF) services, and Targeted Case Management. Aetna maintains a comprehensive network of behavioral health and substance use providers, including:

- Psychiatrists, Psychologists, and Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, and Licensed Clinical Alcohol and Drug Counselors
- Targeted Case Managers and Certified Family, Youth and Peer Support Providers
- Chemical Dependency Treatment Centers
- Psychiatric Residential Treatment Facilities (PRTFs) and Residential Crisis Stabilization Units
- Community Mental Health Centers (CMHCs)
- Behavioral Health Multi-Specialty Groups
- Behavioral Health Service Organizations
- Other independently licensed behavioral health professionals

If you are billing SUD residential services, please note that the service location where the member received treatment MUST be on the claim. The claim/encounter should follow X12 guidelines and report the service location where the member received services if different than the bill to address. To bill the SUD residential service codes (H0011, H2034, H2036), the service location address must have a DMS Provisional or CARF ASAM certification for the level of care that is being billed and be listed on the Department's SUD provider file that is communicated to all MCOs.

Aetna will not accept copies of certifications or approved attestations per the Department's directive. Providers and their service locations must be listed and active on the Department SUD provider file for Aetna to accept and process prior-authorization requests for SUD residential services.

Aetna must cover court-ordered psychiatric inpatient services to members under the age of twenty-one (21) and over the age of sixty-five (65) who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645 (Kentucky Mental Health Act of The Unified Juvenile Code) or KRS 202A (Kentucky Mental Health Hospitalization Act). Aetna cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Providers, members, or other responsible parties should contact Aetna Better Health directly at **1-855 300-5528** to verify available behavioral health and substance use benefits and to seek an appointment or direction for obtaining behavioral health and substance use services

## Requirements for Behavioral Health Services

Aetna Better Health will engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention, and overall person-centered treatment approaches to lower morbidity among members with SMI and SED, including members with co-occurring developmental disabilities, substance use disorders, and smoking cessation.

Aetna, in its design and operation of behavioral health services, incorporates these core values for members:

- Behavioral Health services must be delivered in a culturally competent manner with the application of a health equity lens to the provision of services.
- Members have the right to retain the fullest control possible over their behavior health treatment. Behavioral Health Services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare.
- Aetna will provide the most normative care in the least restrictive setting and serve members in the community to the greatest extent possible.
- Aetna will measure members' satisfaction with the services they receive.

Aetna's behavioral health services shall be trauma-informed, recovery and resiliency-focused.
Aetna Better Health is committed to having an integrated care model that looks at all aspects of a person – physical, emotional, lifestyle, beliefs, and values. We treat behavioral and physical health together. Behavioral health care providers will provide the most normative care in the least restrictive setting and serve members in the community to the greatest extent possible. Behavioral health services will be trauma-informed and recovery and resiliency focused.

Behavioral health providers should use the most current version of the DSM classification when assessing members for behavioral health services and document the DSM diagnosis and assessment/outcome information in the enrollee's medical record. Aetna Better Health may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM.

## Intensive Outpatient Program (IOP) Covered Services & Requirements

Aetna Better Health of Kentucky would like to remind providers about the regulatory requirements for coverage and reimbursement of IOP (H0015/S9480) services.

- An Intensive outpatient program (IOP) is an alternative to or transition from inpatient hospitalization or partial hospitalization from mental health and/or substance abuse disorders.
- An IOP must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intense than individual, group, and family therapies.
- IOP services must be provided at least three (3) hours per day and at least three (3) days per week for adults, and at least six (6) hours per week for adolescents.
- Programming must include individual, group, and family therapy unless contraindicated, crisis intervention as it would occur in the setting where IOP is being provided, and psychoeducation.

These services should be available to the recipients according to their individualized treatment plans. To provide Intensive Outpatient Program services, a provider must be employed by a behavioral health multi-specialty group, CMHC, CCBHC, or behavioral health provider group. In addition, to provide IOP the provider group must have:

- Access to a board-certified or board-eligible psychiatrist for consultation.

- Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management. What does “access to” mean? “Access to” means that the provider group must have a contract with those providers. Please refer to the following applicable KAR. 907 KAR 15:010.

Coverage provisions and requirements regarding behavioral health services provided by individual approved behavioral health practitioners, behavioral health provider groups, and behavioral health multi-specialty groups.

## Behavioral Health Access Standards

Aetna Better Health ensures accessibility and availability of qualified providers to all members and will maintain an adequate network that provides a continuum of care to ensure access to care at the appropriate level.

Members may participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and will provide information on accessible in-network providers with relevant experience. Members will be educated about where and how to obtain behavioral health services.

All behavioral health services shall be provided in conformance with access standards established by the Department. Aetna Better Health ensures access to psychiatrists, psychologists, and other behavioral health service providers. Community Mental Health Centers (CMHCs) are offered participation in the Aetna Better Health’s provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, and other independently licensed behavioral health professions. To the extent that non-psychiatrists and other providers of behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the behavioral health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.

| Behavioral Health & Substance Use Services | |
|---|---|
| **Appointment Type** | **Access/Appointment Standard** |
| Emergent | Within 6 hours for non-life-threatening emergency services |
| Urgent care | Within 48 hours |
| Routine Care Initial Visit | Within 10 days |
| Behavioral Health Hospital Aftercare appointments | Within 7 days after hospital discharge |
| Routine Care Follow-Up/Other referrals | Within 60 days |

Aetna Better Health will ensure that upon decertifying a member at a certain level of care, there is access to providers for continued care at a lower level, if such care is determined medically necessary.

## Behavioral Health Coordination of Care

Aetna will coordinate and collaborate with providers on discharge plans and criteria. Aetna works to identify and develop community alternatives to inpatient hospitalization for those members who are currently receiving inpatient psychiatric facility services and could be discharged from the facility if an appropriate treatment alternative were made available in the community. If an appropriate community

alternative is not available, Aetna is financially responsible for the continued inpatient care of these individuals until the appropriate community provider is available.

Aetna requires through contract provisions that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Communication between behavioral health care providers and the member's PCP helps to ensure members receive coordination of care. The sharing of clinical information promotes quality health care and a comprehensive treatment plan to assess for coexisting medical conditions, medication interactions, or other medical concerns. Behavioral health care providers shall refer members with known or suspected and untreated physical health problems or disorders to such member's PCP for examination and treatment, with the member's or the member's legal guardian's written consent. Behavioral health care providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the member's PCP, with the member's or the member's legal guardian's consent.

Behavioral health providers may only provide physical health care services if they are licensed to do so.

Aetna Better Health of Kentucky requires, through provider contract provision, that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Aetna will ensure through a combination of contractual provisions, provider audits, or provider education that behavioral health service providers contact members who have missed an appointment within twenty-four (24) hours to reschedule appointments.

### Behavioral Health Continuity of Care Upon Discharge from a Psychiatric Hospital

Aetna coordinates with providers of behavioral health services and state operated, or state contracted, psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law and/or voluntarily admitted to the State psychiatric hospital.

Behavioral health service providers are required to participate in quarterly Continuity of Care meetings hosted by the state-operated or state-contracted psychiatric hospital. In addition, Behavioral health service providers must assign a Case Manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as medically necessary to enrollees with severe mental illness (SMI) and co-occurring developmental disabilities who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility for enrollees with SMI.

The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the member's behavioral health, physical health and SDoH needs, including psychosocial rehabilitation and health promotion.

Appropriate follow up by the behavioral health service provider shall occur to ensure the community supports are meeting the needs of the enrollee discharged from a state-operated or state-contracted psychiatric hospital.

Behavioral Health service providers must assist enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

## Behavioral Health Programs and Standards

Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage, are especially important when members use physical and behavioral health systems simultaneously.

Aetna has guidelines and procedures to ensure accessibility, availability, referral, and triage to effective physical and behavioral healthcare, including emergency behavioral health services, suicide prevention and community crisis stabilization. Aetna facilitates the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions. Aeta will evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and PCPs. Aetna protects the confidentiality of member information and records.

Aetna Better Health members have access to integrated care managers for assistance in obtaining both routine and higher complexity health care services. Providers can also contact Aetna Better Health for assistance in facilitating specialty behavioral health services for our members. Aetna Better Health provides a comprehensive range of behavioral health care services for our members. Services include:

- outpatient routine office visits for therapy and medication management
- hospital-based services for both behavioral health and substance use disorders
- home-based therapy services
- access to many helpful community-based resources

Aetna Better Health will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatry services.

Behavioral health programs and social work services are also available through Aetna Better Health Social Workers. For information about our integrated care management programs or to make a referral, call **1-888-470-0550**

## Behavioral Health Substance Use Disorder Residential Services Billing Guidance

When billing SUD residential services, the service location where the member received treatment must be on the claim. The claim/encounter should follow X12 guidelines and report the service location where the member received services if different than the bill-to address. To bill the SUD residential service codes (H0011, H2034, H2036) the service location address must have a DMS Provisional or CARF ASAM certification for the level of care that is being billed.

# Pharmacy Services

## Prescribing Outpatient Medications for Members

The Aetna Better Health pharmacy benefit through the Commonwealth of Kentucky's single pharmacy benefit manager, MedImpact, covers medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides FDA approved outpatient prescription medications that are clinically proven to be safe and effective.

Providers and pharmacists are encouraged to refer to the single preferred drug list at https://kyportal.medimpact.com/sites/default/files/2023-12/kentucky-medicaid-pdl.pdf or a list of preferred drugs covered under the KY PDL when selecting prescription drug therapy for eligible members.

## Pharmacy Benefit Manager

MedImpact administers the prescription drug benefit for Aetna Better Health of Kentucky. Pharmacies should process claims for Aetna Better Health of Kentucky members through the TelePAID System with the Member ID number, RxBIN1023880, RxGROUP KYM01. This information along with the prescriber and dispensing pharmacy's NPI number are mandatory fields for successful claims processing. The MedImpact contact numbers and website are:

- RXBIN .....**023880**
- RXPCN.....**KYPROD1**
- RXGRP .....**KYM01**
- MedImpact: 800-210-7628
- Pharmacy Prior Authorization phone number: **844-336-2676**
- Pharmacy Prior Authorization fax number: **858-357-2412**
- https://kyportal.medimpact.com/provider-forms/provider-forms

## Prescribing Practitioners

The Commonwealth of Kentucky requires that prescribers have a valid, active NPI (National Provider Identification Number) and valid, active MAID (Medicaid Identification Number). Prescriptions from prescribers who do not have both numbers will be rejected at the point of sale.

## Pharmacy Network

Through the state's program, any Medicaid-enrolled pharmacy is eligible. To find a pharmacy, please visit the pharmacy locator tool: https://openenrollment.medimpact.com/#/plancode?KYM01202101

## Covered Drugs and Services

All outpatient drugs, including over the counter (OTC) drugs, are now covered under a single KY formulary and Preferred Drug List (PDL) managed by MedImpact. This does not include Physician Administered Drugs, which will continue to be managed by Aetna Better Health of KY, under the medical benefit. Please visit https://kyportal.medimpact.com/sites/default/files/2023-12/kentucky-medicaid-pdl.pdf for a list of preferred drugs covered under the KY PDL.

## Formulary

Please visit https://kyportal.medimpact.com/sites/default/files/2023-12/kentucky-medicaid-pdl.pdf for a list of preferred drugs covered under the KY PDL.

## Pharmacy Help Desk

Questions regarding pharmacy coverage can be directed to MedImpact at **1-800-210-7628.**
The pharmacy help desk is available 24 hours a day, 7 days a week. Providers may also fax prior authorization requests to **1-858-357-2612.**

## Non-Covered Drugs

The following is a listing of non-covered drugs:

- Drugs that are not medically necessary
- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purposes other than treatment for severe acne and agents used to treat baldness.
- Experimental and investigational medication, drugs with no approved Food and Drug Administration (FDA) indications, and drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other peer-reviewed medical literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- Any drug marketed by a company (or labeler) that does not participate in the Fee for Service (FFS)
- Medicaid Drug Rebate program in accordance with Section 1927 of the Social Security Act, 42
- U.S.C.A 139r-8
- Any product designated by the FDA as a Drug Efficacy Study Implementation (DESI) drug
- Drugs for the treatment of sexual or erectile dysfunction. Amendments to Title XIX of the Social Security Act prohibit Federal Financial Participation (FFP) under Medicaid for these drugs when used to treat sexual or erectile dysfunction.
- Drugs used to treat infertility
- Drugs used to treat weight loss

## Copays

Through the Commonwealth of Kentucky's single pharmacy benefit manager there are no copays for pharmacy benefits

# Other Programs

## SKY Member Information

Aetna Better Health of Kentucky is proud to have been the sole MCO selected to serve all children in Kentucky's out of home care system. This included

- Children and youth in foster care
- Children and youth in Juvenile Justice who are Medicaid eligible
- Children and youth placed in kinship/ fictive kin care
- Children and youth dually committed to DCBS and DJJ
- Children and youth who are receiving interstate adoption assistance
- Children and youth 18 and under who are eligible due to being in an out of state relative placement
- Adoption assistance children and youth
- Former foster youth
- Consolidated Appropriations Act (CAA)

We are here to provide direct support to members, foster parents, adoptive parents, caregivers, DCBS and DJJ workers. The SKY Member Companion Guide (linked below) explains how the SKY Medicaid Program works. It includes helpful resources for SKY members and their circle of support. It will explain what services and supports are available by the SKY Medicaid program and the roles of the Primary Care Provider (PCP) and Primary Dental Provider (PDP), Care Coordination team, DCBS and DJJ workers.

- SKY Program Website
- SKY Program Information
- SKY Companion Guide
- Extra Benefits for ABHKY Members

## Care Management Integrated (Care Management and Disease Management)

Integrated Care Management (ICM) is designed to identify our most bio-psycho-socially complex and vulnerable members with whom we have an opportunity to make a significant difference. We engage these members in integrated care management programs to remove or lessen barriers that limit their ability to manage their own health and well-being, to educate them about their chronic conditions, and to help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports.

Autonomy and active self-management of acute and chronic conditions is encouraged where clinically appropriate, with tools and education directed at each member's unique needs and health literacy. A well- trained case manager serves as the single point of contact for the member.

We collaborate with the member, member support, and/or integrated care team to create a plan of care that includes mutually agreed upon member-centered goals and actions for the member/member supports. The case manager and the care team arrange for both covered and non-covered services to be coordinated for the member.

All members will receive person-centered outreach and follow-up, from those who are healthiest to those who are the sickest or most at-risk due to their medical, behavioral, and/or social comorbidities; pregnant women, mothers, and children in TANF; the aged, blind, and disabled (ABD); members who have a chronic illness, severe and persistent mental illness, or disability. The case manager may work with the member telephonically or meet with the member in a setting that is best for the member.

The integrated care management program is "integrated" as it reflects our belief that care management must address the member's medical, behavioral, and social needs in an integrated fashion and must address the continuum of acute, chronic, and long-term services and support needs. Case managers assist members in coordinating medical and/or behavioral health services as well as those available in the community and/or that are not covered in the member's benefits package.

Any psychosocial issues and cognitive limitations that impact the member are incorporated into their individualized care plan as are the cultural practices and beliefs that are most important to the member. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the case manager and the member better understand what has prevented full engagement with a suggested clinical treatment or plan of care. Once these issues are identified by the member and informed by the care team, true individualized and collaborative care planning can begin.

The ICM Program manages the unique needs of each member's experience. Whether they have short- term acute needs or long-standing chronic health issues or need information, resources, or care coordination the program can be tailored to that specific member's situation. Using available information, we employ clinical algorithms and case manager judgment to recommend a level of integrated care management that is best suited to address the member's needs. All Medicaid program types are included (e.g., TANF, ABD, CHIP, dually enrolled) and drive the services and interventions that the member receives.

If you have patients that need ICM or have any questions about these services, Call Member Services at **1- 855-300-5528**, 7 a.m. to 7 p.m. ET, Monday–Friday, and ask to speak to a case manager. Involvement in the ICM program is voluntary. Members have the right to opt out of the ICM program at any time.

## Dental Services

Dental services are covered for eligible Aetna Better Health members. Aetna Better Health is contracted with Skygen for the provision of these services.

Providers, members, or other responsible parties may verify dental benefits by contacting Skygen at (888) 983-4701 (providers) or (800) 882-5883 (members).:

Providers are encouraged to sign up with Skygen's Dental HUB for administrative tasks via the link
https://www.dentalhub.com/webinars

**Phone**: (855)-609-5156
DentalHubSupport@skygenusa.com

The website also contains important information including, but not limited to, Dental Alerts, eligibility verification, claims submission, and claims status. Members with dental benefits may self-refer to participating dental providers for routine office level dental services. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury are also covered services.

**Dental Prior Authorization**

Aetna Better Health requires prior authorization for dental procedures that are scheduled as outpatient and/or inpatient cases. For example, facility costs associated with dental care under anesthesia would require prior authorization from Aetna Better Health.

For questions, please call our PA department at **1-888-725-4969** or send via secure fax at **1-855-454 5579**.

Some services provided by a licensed M.D (medical doctor) may be covered by Aetna Better Health and not (e.g., trauma to the mouth/jaw, etc.).

## Care Management and Support Available from Aetna Better Health of Kentucky

Aetna Better Health educates members about the importance of EPSDT screenings. Aetna Better Health sends member reminders when members are due for screenings and provides follow-up reminders if screenings are not completed. Aetna Better Health also provides scheduling assistance for those members who are eligible.

Aetna Better Health also provides care management services, including care management programs, disease management programs, and social work assistance for our members with special needs, complex medical conditions, or chronic medical conditions.

## Special Needs Case Management

Members with special health care needs are those members who have ongoing special conditions that require a course of treatment or regular care monitoring. An assessment is completed on all members identified with a special health care need. The assessment consists of identifying issues, such as, but not limited to, eligibility status, PCP and/or specialty provider access, coordination of care for durable medical equipment (DME), therapy, home health services, behavioral health, and/or dental access. Further evaluation includes the member's and/or family's ability to remain compliant with a treatment plan and/or follow-up care requirement, general understanding of the clinical and quality of life risks when intervention is not provided, and the complexity of the clinical case. The Special Needs Coordinator educates the parent/guardian on Kentucky Medicaid Managed Care benefits.

For members with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, Aetna Better Health participates in transition planning and continued care coordination. The Special Needs Coordinator will complete a comprehensive physical and behavioral health assessment to support the successful transition to community-based housing within fourteen (14) days of transition by reviewing the member's Person- Centered Recovery Plan and level of care determination developed by the provider, as well as collaborating with the UM Department to ensure recommended services are reflected in the Person- Centered Recovery Plan and meet medical necessity criteria.

Children in Commonwealth of Kentucky custody, foster care, or guardianship are evaluated for integrated care management to ensure that the coordination and documentation of care is consistently performed in a timely manner.

## Completion of Special Reports or Forms for Members

Preparation of special reports including, but not limited to, return to work/school forms, etc. are not considered reimbursable by Aetna Better Health and are not billable to the member.

## EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program for children. In the Commonwealth of Kentucky, it is divided into two components: EPSDT Screenings (discussed below) and EPSDT Special Services.

The EPSDT Screening Program provides routine physicals and well-child checkups for Medicaid eligible children at certain specified ages. It is considered preventive care. Children are checked for medical problems early. Specific tests and treatments are recommended as children grow older. EPSDT Special Services are services for members under the age of 21 not covered by the Kentucky Medicaid Program. EPSDT Special Services are provided as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8. Those EPSDT diagnosis and treatment services and EPSDT Special Services which are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to prior authorization by the Contractor, as specified in 907 KAR 1:034, Section 9. Approval of requests for EPSDT Special Services shall be based on the standard of medical necessity specified in 907 KAR 1:034, Section 9.

### EPSDT Covered Services

The areas of health care that are checked include preventive checkups, growth and development assessments, vision, hearing, dental, immunizations, and laboratory tests.

Children should receive health checkups regularly or before the following ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and once a year
for ages 3–20. Documentation of these evaluations should be recorded in the child's medical record.

### EPSDT Tracking/Member Outreach

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The

parent/guardian may also refuse to allow the child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian regarding the importance of these services. If the parent/guardian continues to refuse the service, the child's medical record must document the reason the service was not provided.

Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work were refused. By fully documenting in the child's medical record the reason for not providing these services, the provider may bill a full medical screening service even though all components of the full medical screening service were not provided.

Aetna Better Health requires providers maintain adequate fiscal and medical records that fully disclose services rendered, retain these records for at least seven (7) years, and make them available to appropriate Aetna Better Health staff, state, and federal officials on request.

**EPSDT Billing/Reporting**

EPSDT screening services must be reported with the age-appropriate evaluation and preventative medicine CPT Codes along with the EP modifier. An appropriate procedure code must be submitted on the CMS 1500 form. The primary diagnosis should be submitted as the first diagnosis in field 21 of the CMS claim form. Additionally, this same primary diagnosis must be reflected on the appropriate line-item diagnosis item (field 24 E).

The appropriate services associated with the EPSDT screening must be rendered and the codes for these services included in the claim with an EP modifier accompanying **each code**. EPSDT claims must be billed on a CMS 1500 form. Please refer to the billing instructions at www.chfs.ky.gov.

**Preventive Medicine Services: New Patients**

| CPT Codes | | ICD-10-CM Codes | |
|---|---|---|---|
| **99381** | Infant (younger than 1 year) | **Z00.110** | Health supervision for newborn under 8 days old **or** |
| | | **Z00.111** | Health supervision for newborn 8 to 28 days old **or** |
| | | **Z00.121** | Routine child health exam *with abnormal findings* **or** |
| | | **Z00.129** | Routine child health exam *without abnormal findings* |
| **99382** | Early childhood (age 1-4 years) | **Z00.121** | |

| | | | |
|---|---|---|---|
| 99383 | Late childhood (age 5-11 years) | Z00.129 | |
| 99384 | Adolescent (age 12-17 years) | | |
| 99385 | 18 years or older | Z00.00 | General adult medical exam *without abnormal findings* |
| | | Z00.01 | General adult medical exam *with abnormal findings* |

**Preventive Medicine Services: Established Patients**

| CPT Codes | | ICD-10-CM Codes | |
|---|---|---|---|
| 99391 | Infant (younger than 1 year) | Z00.110 | Health supervision for newborn under 8 days old **or** |
| | | Z00.111 | Health supervision for newborn 8 to 28 days old **or** |
| | | Z00.121 | Routine child health exam *with abnormal findings* **or** |
| | | Z00.129 | Routine child health exam *without abnormal findings* |
| 99392 | Early childhood (age 1-4 years) | Z00.121 | |
| 99393 | Late childhood (age 5-11 years) | Z00.129 | |
| 99394 | Adolescent (age 12-17 years) | | |
| 99395 | 18 years or older | Z00.00 | General adult medical exam *without abnormal findings* |
| | | Z00.01 | General adult medical exam *with abnormal findings* |

Aetna Better Health will provide coverage for an office visit performed at the same time as the EPSDT screening if the child was seen for a reason other than the EPSDT screening (e.g., sick child visit). Additionally, Aetna Better Health will provide coverage for an EPSDT screening performed during a prenatal visit for members aged 20 and under.

**Modifier EP (EPSDT Services)**

Modifier EP is available for use with evaluation/management codes when the member is under age 21 on the date of service. Using the EP modifier is required for EPSDT services provided to a member. Modifier SL must be used when billing Vaccines for Children (CFC) immunizations. Refer to Section 2 or more information on billing VFC services. Modifier 26 is no longer used.

**EPSDT Practitioner Eligibility**

Fully trained EPSDT providers who meet the requirements set forth under 907 KAR 11:034 and who are supported by adequately equipped offices to perform EPSDT services are deemed eligible.

**EPSDT Referrals**

Should the PCP be unable to provide all the components of the EPSDT exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within the ABHKY network that is qualified to treat the condition. It is the responsibility of the referring agencies/providers to follow up on this referral to determine if treatment was initiated.
Quality audits may also examine if providers are initiating this follow-up. The following list includes specialists and agencies to whom a member can be referred:

- Dentists
- Pediatricians
- Sub-specialty agencies/physicians
- Specialty agencies
- Health department clinics
    - Tuberculosis (TB) clinic
    - Women Infants and Children (WIC) program
    - Maternity clinic
    - Family planning
    - Lead clinics
    - Behavioral health providers

## Components of a Full Medical Screen

The following are required for an exam to qualify as an EPSDT exam:

- A comprehensive unclothed physical examination
- A comprehensive health and developmental history, including assessment of both physical and behavioral health developments
- Health education (including anticipatory guidance)
- Appropriate immunizations according to age
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated)
- Lead screening at every EPSDT visit from six (6) months of age to six (6) years of age (A serum lead level lab test should be completed no less than by one (1) year of age and again by two (2) years of age regardless of the outcome of lead screening. Lead levels should also be completed whenever the lead screening identifies the member as at risk for an elevated lead level).
- Hearing screening

- Vision screening
- Dental screening beginning with the first tooth eruption (but no later than one (1) year of age even if a tooth has not erupted)

The next sections provide details on the components of the exam.

**Interval History/Parent's Concerns/Child's Concerns**

The purpose of a health and developmental history is to gather information about diseases and health problems for which no standard screening test has been developed and to compile historical information about the child and the family. Answers to a standard set of questions can identify those children who may be at a substantial risk of a significant health problem. The health and developmental history should also provide information about siblings, growth history, conditions suffered by blood relatives, previous medications, immunizations, allergies, and a developmental history of the child as well as other family members.

**Nutritional Assessment**

The assessment of a child's nutritional status and eating habits (and the use of alcohol and tobacco) are taken at the time of the physical examination. Evaluation is also suggested for the following groups:

- Children who demonstrate weight loss or no weight gain over a period
- Children who are considerably overweight in proportion to their height or greater than the 85th percentile according to the Center for Disease Control Body Mass Index (CDC BMI) for age growth chart. Refer to the document library on the Aetna Better Health website at AetnaBetterHealth.com/Kentucky for a copy of the BMI for age growth chart,
- Other variations from expected growth parameters, such as weight for age and height for age, below the 5th percentile
- Diseases in which nutrition plays a key role, such as cardiovascular disease, hyperlipidemia, gastrointestinal disorders, hypertension, metabolic disorders, and physical and mental handicaps affecting feeding, allergies, and surgery. If information suggests dietary inadequacy, obesity, or other nutritional problems, further assessment is indicated, including:
    - Family, socioeconomic, or any community factors
    - Determining quality and quantity of individual diets (i.e., dietary intake, food acceptance, meal patterns, methods of food preparation/preservation, and utilization of food assistance programs)
    - Further physical and laboratory examinations
    - Preventive treatment and follow-up services, including dietary counseling and nutrition education
    - Intervention for those children considered to be at risk (85th percentile of BMI)

**Unclothed Physical Examination**

The unclothed physical examination includes specific screening elements as appropriate for the child's age and health history:

- General appearance
- Body measurements
- Skin evaluation

- Blood pressure
- Auscultation of heart and palpation of femoral arteries
- Pulmonary evaluation/auscultation of the lungs, chest configuration, and respiratory movements
- Pulse
- Abdominal evaluation of musculature, organs, masses
- Urogenital evaluation
- Vocalization and speech for appropriate age
- Facial features evaluation
- Neurological evaluation, including gross/fine motor coordination
- Orthopedic evaluation, including muscle tone and scoliosis
- Ears, eyes, nose, and throat inspection

**Anticipatory Guidance**

Health education is a required component of screening services and includes anticipatory guidance. Health education and counseling to parents/guardians as well as children are required and designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles, practices, and accident and disease prevention.

**Labs/Immunizations**

Appropriate immunizations for the child's age and health are required under the EPSDT program. Refer to the Advisory Committee on Immunization Practices at http://www.cdc.gov/vaccines/schedules/index.html.

Laboratory procedures appropriate for the individual's age and population groups are required under the EPSDT program. Analysis of the hemoglobin/hematocrit, urinalysis, and TB skin test are included in the all- inclusive fee for screening.

The following lab procedures are recommended for the appropriate population group:

- Sickle cell test - As of August 1988, infants are screened for the presence of sickle hemoglobin (hemoglobin S). For children born prior to 1988, it is recommended that hemoglobin electrophoresis is performed and that results are recorded in the child's medical record. Diagnosis for sickle cell trait may be done with sickle cell preparation or a hemoglobin solubility test. If a child was properly tested once for sickle cell disease, it is not necessary to repeat the test.
- Tuberculin test - Tuberculosis services include screening, diagnosis, and treatment. Aetna Better Health providers shall follow current CDC/American Thoracic Society Guidelines: Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children, or their equivalent, including the use of Mantoux Purified Protein Derivative (Mantoux PPD) skin test to screen for tuberculosis.
- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.
- All members receiving treatment for tuberculosis disease shall be referred to the local public

health agency's tuberculosis contact for directly observed therapy. Aetna Better Health shall communicate with the local public health agency's tuberculosis contact to obtain information regarding the member's health status. Aetna Better Health shall communicate this information to the provider. Aetna Better Health shall be responsible for care coordination and medically necessary follow-up treatment.

- All laboratory tests for tuberculosis shall meet the standards established by the Center for Disease Control, Department of Health and Social Services.
- Hemoglobin/hematocrit - Recommended at 6–12 months of age or as indicated.
- Urinalysis - As indicated.
- Serum cholesterol - A serum cholesterol determination should be considered in those with a family history of early heart disease and/or hypertension and stroke.

**Lead Screening & Testing**

All children should have a serum lead test by one (1) year of age and again by two (2) years of age. Additionally, lead screening should occur at every EPSDT visit from six (6) months of age to six (6) years of age.

**Development Personal-Social and Language**

The Department of Health and Senior Services and Centers for Medicare and Medicaid (CMS) define a developmental assessment as the range of activities surrounding the examination of the child, adolescent, and young adult to determine whether they fall within the normal range of achievement for the child's age group and cultural background. The developmental assessment is performed at the time of the screening for all ages. Information from the parent or others with knowledge of the individual, direct observation, and talking with the member are utilized to assess the individual's behavior.

It is recommended to include the following elements in the developmental assessment of children of all ages:

- Communication skills, focusing on expression, comprehension, and speech articulation
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children/adolescents, parents, and other adults
- Cognitive skills, focusing on problem solving and reasoning

**Fine Motor/Gross Motor**

It is recommended to include an assessment of fine motor and gross motor development for children of all ages.

**Hearing**

Children should be tested using an appropriate test such as the Weber, Rinne, or Puretone Audiometric evaluation along with history from the parent/guardian.

**Vision**

Administration of age-appropriate vision assessment:

- General external examination and evaluation of ocular motility
- Gross visual acuity examination with fixation test
- Testing light sense with pupillary light reflex test
- Intraocular examinations with ophthalmoscope

Standardized testing methods include visual acuity test for distance on each eye. The Illiterate E test, the STYCAR (Screening Test for Young Children and Retardates), or the Lippman Matching Symbol Chart - HOTV Eye Chart may be utilized. Children four (4) and five (5) years of age should be tested at 10 to 15 feet.

To determine muscle balance, a cover test and the Hirschberg test (corneal light reflex) should be given. Parents should be asked if they have noticed the child's eyes turn in or out.

All individuals ages 5–20 years should be evaluated for distance visual acuity utilizing the Illiterate E or the Snellen letters for a linear fashion. The test should be at 20 feet.

Individuals who wear glasses should be tested while wearing their glasses.

**Dental**

The American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend that children should see a dentist:

- When the first tooth appears or no later than the first birthday
- Twice a year for preventive services
- If there is evidence of infection, inflammation, discoloration, malformation of the dental arches, or malformation or decay of erupted teeth

## Emergency Services

Emergency Care shall be available twenty-four (24) hours a day, seven (7) days a week.

An emergency medical condition is a medical or behavioral health condition manifesting itself by acute symptoms of enough severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency
- Injury to self or bodily harm to others
- With respect to a pregnant woman having contractions: (1) inadequate time to affect a safe transfer to another hospital before delivery, or (2) transfer may pose a threat to the health or safety of the woman or the unborn child

Aetna Better Health may contact members and providers that inappropriately seek routine and non-

emergent services through emergency room visits to educate the members on visiting their PCP's for routine services and/or treatments.

Members that utilize ground ambulance transportation under the prudent lay person's definition of emergency will not require authorization for the ambulance service.

Providers must have a current Commonwealth of Kentucky Medicaid provider identification number submitted with each claim. **Claims for providers without an active Medicaid ID will be denied.**

**Note:** The Contractor shall not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. An emergency medical services provider shall have a minimum of ten (10) calendar days to notify the Contractor of the member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending provider determines that the member is sufficiently stabilized for transfer or discharge.

### Out-of-Service Area Care

Aetna Better Health will reimburse non-participating providers for the evaluation and/or stabilization of emergency conditions according to Commonwealth guidelines, as described above and in accordance with Section 6085 of the Deficit Reduction Act of 2005. Aetna Better Health will accept the attending provider's determination and continue reimbursement at an emergent level if the member's medical stabilization has not been achieved.

### Urgent Care Services

Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

### Family Planning

The Aetna Better Health confidentiality policy must extend to minors when the minor is requesting family planning or other reproductive health services. The parent/guardian of the minor requesting information must demonstrate the member's consent prior to the release of information regarding family planning and/or other reproductive health services.

All information shall be provided to the member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible within a maximum of thirty (30) days. If it is not possible to provide complete medical services to members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away, preferably within ten (10) days. Adolescents shall be assured that family planning services are confidential and that any necessary follow- up will ensure the member's privacy. Aetna Better Health members can receive family planning services from any Medicaid-enrolled provider and is not restricted to receiving services from an Aetna Better Health participating provider.

Sterilization procedures follow the Commonwealth of Kentucky guidelines and are not covered for members under the age of 21. Members must sign the sterilization consent form at least thirty (30)

days but not more than one hundred eighty (180) days prior to the date of the sterilization procedure. Please refer to the CHFS website to access the appropriate form for this procedure: http://chfs.ky.gov/dph/info/dpqi/phpr+forms+and+teaching+sheets.htm.

## Health and Disease Management Programs

Based on the member's needs, case managers use condition-specific assessments and care plan interventions to assist them with chronic condition management, thereby including traditional "disease management" within the ICM process rather than it being managed separately. Members with diabetes, COPD, heart failure, asthma, depression, chronic kidney disease, and coronary artery disease are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, and concurrent review/prior authorization referral, as well as member and provider referral.

## Supportive Managed Care Program

The Supportive Managed Care Program is an approved Medicaid Program to give support to members who need assistance in managing health care needs. The program helps members manage their medical care. This program doesn't stop a member from getting the care they need. Instead, members get coordinated care when they use one doctor, one pharmacy, and one hospital.

Member claims data is reviewed to identify members who have visited multiple providers, hospital emergency departments, and/or pharmacies.

Aetna Better Health can enroll the member with one or more providers that will support the member's establishment of a medical home and healthful prescription habits.

Someone who is in the Supportive Managed Care Program may only have access to one of each of these:

- One primary care provider
- One pharmacy
- One hospital

Members will be limited to selected providers for a period of twenty-four (24) months. Aetna Better Health will monitor the claims and pharmacy use of Supportive Managed Care Program members at least annually after the initial 24-month limited period.

If the member switches health plans, their assignment will follow them to their new health plan. Members determined by Aetna Better Health to be enrolled in the Supportive Managed Care Program will be provided with written notice of his/her enrollment in the program.

Enrollment in the Supportive Managed Care Program will be effective within sixty(60) days from the date the member is provided written notice. A member will have the right to appeal his/her enrollment in the program by providing additional information as to why his/her enrollment is inappropriate.

A designated primary care provider must meet the following requirements:

A. Must meet the normal time and distance access standards. See Section 4 for Provider Access Standards

B. Shall provide and manage service for the Supportive Managed Care member's health care needs
C. If the Supportive Managed Care Program member requires a covered service that the designated primary care provider cannot provide, the Supportive Managed Care provider will refer the member to an Aetna Better Health provider who can provide the necessary service. It is important the designated provider completes a Lock-In referral form and/or notifies the Supportive Managed Care staff with the provider the member is being referred. This form can be located on the Aetna Better Health website at AetnaBetterHealth.com/Kentucky. Click the For Providers Tab and then search under the Document Library.
D. Must complete periodic assessment of the Supportive Managed Care member's compliance with the terms of the Supportive Managed Care Program

A designated Supportive Managed Care pharmacy and/or Emergency Department must also meet the normal time and distance standards for the community in which the member resides. Members may access emergency services from any provider.

Prior to a service, providers should determine whether a member is in the Supportive Managed Care Program as Supportive Managed Care recipients are restricted to certain providers. Treatment of a Supportive Managed Care member for non-emergency services by a provider who does not serve as the member's assigned provider may not be reimbursed by Aetna Better Health.

## Obstetrical - Maternity Care Overview

Once an Aetna Better Health member is found to be pregnant, the provider must notify our Integrated Care Management Department by calling Member Services **1-855-300-5528** or via fax at **1-855-454- 5044**, using the Aetna Better Health Maternity Risk Screening form. Please refer to the Document Library on the Aetna Better Health of Kentucky website at AetnaBetterHealth.com/Kentucky for a copy of the form.

- One ultrasound is allowed after fourteen (14) weeks with notification only. Any additional ultrasounds require prior authorization and will be reviewed for medical necessity.

### High Risk OB Program

Our goal is to have healthy mothers and babies. To meet that goal, Aetna Better Health has developed a maternal and child program in conjunction with the members' obstetrical providers. This program promotes prenatal screenings and interventions in order to identify potential high-risk factors and monitor prenatal visit compliance.

### Maternity Matters Program

Maternity Matters™ will be offered as a preventive health program for pregnant members and new mothers and is filled with benefits and incentives to reduce premature births and mortality and to encourage care. Incentives are received via a reloadable card. The funds earned can be used for healthy foods, maternity supplies, and diapers at a variety of local and online stores.

### Cribs for Moms Program

Aetna Better Health offers a care management pregnancy coaching program with an incentive of a "free" portable crib for pregnant women who attend a prenatal visit with their obstetrical provider

within forty- two (42) days of enrollment.

Aetna Better Health encourages moms to eliminate all items in the crib to keep baby safe during sleep. This program is provided to pregnant moms participating in the program prior to delivery. Members may call the HEDIS Department to enroll early for this benefit at **1-855-737-0872.**

**Obstetrics Observation/Inpatient Admission Authorization**

During pregnancy, the maternity provider assumes the responsibility of coordinating the member's care for OB-related conditions. Aetna Better Health authorizes 4-day admission stays for routine vaginal deliveries and uncomplicated cesarean deliveries. The attending physician and mother may determine that an earlier discharge is in the best interest of the family.

**Newborns**

Most newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health by the Cabinet for Health and Family Services, except when eligibility does not allow automatic enrollment. Most newborn infants will be deemed eligible for Medicaid and will be automatically enrolled with Aetna Better Health as individual members for sixty (60) days. Deemed eligible newborns are auto enrolled in Medicaid and enrollment is coordinated within the Cabinet.

The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). The information is used to auto enroll the deemed eligible newborn within twenty-four (24) hours of birth.

Unless the mother selects a different Medicaid Managed Care plan, newborns born during the mother's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health. The Commonwealth enrollment process must be completed to ensure timely and accurate claims processing of newborn claims. Any service payment issues related to newborn care should be directed to your Network Manager at **1-855-300-5528**.

Newborn claims will be denied until a valid Commonwealth of Kentucky Medicaid ID number is on file for the newborn. Hospital social service coordinators or local DCBS caseworkers usually initiate the process of educating and facilitating the mother of an Aetna Better Health newborn to complete the Medicaid enrollment process. However, it is the mother's responsibility to ensure a newborn is enrolled with Medicaid within sixty (60) days of birth.

Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the Commonwealth. Delayed newborn enrollment may cause a delay in claim reimbursement for providers. Contacting the Commonwealth and/or your Network Relations Manager will facilitate the correction of the delayed enrollment, and instructions on the process to submit your claim(s) will be provided.

If the mother has not selected a PCP for the newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

## Sterilization Procedures Policy

Aetna Better Health is required to comply with the standard Commonwealth of Kentucky and federal regulations regarding sterilization procedures. The following criteria must be met for payment

consideration:

- The member must be at least 21 years of age.
- The member must be mentally competent at the time the surgery is performed.
- The waiting period from the time the consent form is signed to the day of the surgery must allow for a full 30-day waiting period not to exceed one hundred eighty (180) days from the consent date.
- The member must be eligible with Aetna Better Health on the date of service.

Aetna Better Health does not require prior authorization. Providers must submit the consent form with the claim for processing. Reimbursement cannot be made to the provider if the Commonwealth requirements are not met. Please refer to the Document Library on the Aetna Better Health website at AetnaBetterHealth.com/Kentucky for a copy of the Sterilization Consent form.

### Pediatric Sexual Abuse Examination

Pediatric sexual assault forensic examinations are reimbursed by the Kentucky Medicaid fee-for-service program. Authorization is required.

### Reference Laboratory Services

Outpatient reference laboratory services must be directed to a contracted laboratory provider. Please refer to the provider search on the Aetna Better Health of Kentucky website at AetnaBetterHealth.com/Kentucky for a complete listing of contracted laboratories.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied.

### Transplant Management

Transplant services are part of the Kentucky Medicaid managed care benefit. All transplant requests must be pre-authorized by Aetna Better Health and must be performed at an Aetna Better Health approved transplant facility.
Note: not all Aetna Better Health network hospitals are approved transplant facilities
**Please fax all requests related to transplant services to 855-454-5579 or 833-689-1422 for SKY Members**

### Transportation Services

Transportation services are available for eligible members through the Human Service Transportation Delivery (HSTD) program. CHFS contracts with HSTD to provide this service. More information regarding non-emergency transportation services can be found at www.chfs.ky.gov.

Aetna Better Health of Kentucky adheres to Kentucky State Regulation 907 KAR 1:060 Ambulance Transportation and categorizes Ambulance Medical Transportation as Non-Emergency Medical Transportation and Emergency Medical Transportation via ground or air (rotary or fixed wing) methods.

Aetna Better Health requires the necessary documentation for all transports upon claim submission within 12 months of the transport regardless of if the service requires prior authorization. Please include all supporting medical necessity and hospital clinical documentation, along with the Physician Certification Statement for Non-Emergency Ambulance Services (PCS-01) form upon claims submission.

Utilization Management staff members are responsible for coordinating, and, if applicable, authorizing non-emergent facility to facility and facility-to-place of residence ambulance transportation for members.

Additional Aetna Better Health of Kentucky policies supporting Transportation Services, including those defining medical necessity:

- A-KY 4500.95 Emergent and Non-Emergent Transportation
- A-KY 7100.05 Prior Authorization

**Non-Emergency Medical Transportation**

Aetna Better Health is responsible for the provision of non-emergent medical transportation by stretcher for members.
Non-emergent medical transport, by ground, does not require authorization for PAR (In-Network) Providers. This includes:

- Stretcher van transport
- Elective transport from place of residence to non-emergent medical services.
- Elective transport from a medical facility to place of residence, including after-hours.
- Elective transport from a nursing home to a medical facility.
- Elective transports from a hospital to a hospital to include:
    - Members who are receiving medical care at a hospital facility, including Emergency Room services.
        - An emergency ambulance service shall be covered to and from a hospital in the medical service area if:

            (a) The service is medically necessary [MWA1]; and

            (b) Documentation is maintained for post payment review to indicate immediate emergency medical attention was provided in the emergency room. [MWA2]

- Non-emergent medical transport by air (rotor or fixed wing) requires an authorization for both Par and Non-Par providers, which includes:

    - Elective transports from a hospital to a hospital whereas:
        - Members who are receiving medical care at a hospital facility, including Emergency Room services.
            - An emergency ambulance service shall be covered to and from a hospital in the medical service area if:
                (a) The service is medically necessary; and

(b) Documentation is maintained for post payment review to indicate immediate emergency medical attention was provided in the emergency room.

If a patient is receiving treatment at a hospital and experiences real-time deterioration in their clinical condition necessitating immediate transport to a higher level of care, by air, whether rotor or fixed wing, the ambulance provider should provide necessary services and not delay care. Ambulance providers may request a post-service authorization by faxing our Retrospective Review Department at **855-336-6054** within twelve (12) months, prior to claim submission. Please include all supporting medical necessity and hospital clinical documentation, along with the Physician Certification Statement for Non-Emergency Ambulance Services (PCS 01) form. Post-service authorization requests are subject to Aetna Better Health of Kentucky's Utilization Management Timeliness Standards.

**Emergency Medical Transportation**
Emergent medical transport, ground, or air, by stretcher does not require an authorization and is provided for all members by calling 911 or the local emergency service number.

Emergent medical transport, ground, or air, by stretcher includes:

- Emergent transport from a place of residence to a hospital.
- Emergent transport from the scene of the accident to a hospital.
- Emergent transport from the scene of an accident to the safest landing zone for air ambulance to provide transport to a hospital.

Ambulance providers may follow the standard claim submission process after services have been rendered.

## Vision Services

Aetna Better Health of Kentucky contracts with Avēsis for vision services to our members. Avēsis administers full comprehensive eye care services, which includes routine and medical vision services. Medical eye care coverage can include the detection, treatment, and management of ocular and/or systemic conditions that produce ocular or visual symptoms. Covered members may seek care from a participating provider.

**Member Eligibility Verification**
Members are eligible to receive one (1) exam of eye health and visual acuity per calendar year. Members have a material allowance per calendar year for lenses and frames. Elective contact lenses are not covered. A medically necessary contact lens fitting is covered if criteria are met. Members do not have an out-of-network benefit.

**Vision Services Program Fact Sheet**
Covered benefits are administered in accordance with the Avēsis policies and procedures in effect upon the date of service. Procedure codes are only covered within your scope of licensure as well as the current laws, rules, and regulations as determined by the Commonwealth and Federal Government.

**Conditions Covered under Aetna Better Health Medical Benefit**

Examples of conditions may include, but are not limited to:

- Ocular hypertension
- Glaucoma
- Conjunctivitis
- Corneal dystrophy
- Blepharitis
- Retinal nevus
- Cataract
- Macular degeneration
- Corneal abrasion
- Chalazion-Hordeolum

For more information, please call your Network Relations Manager or Avēsis at **1-855-214-6777**.

**Claim Submission for Vision Services**

Claims for vision services should be submitted to:

Avēsis
P. O. Box 38300
Phoenix, AZ 85069
**1-855-214-6776**

# Acronyms

| | |
|---|---|
| **ABA** | Applied Behavioral Analysis |
| **ACA** | Affordable Care Act |
| **ALF** | Assisted Living Facility |
| **Atypical Provider** | CMS defines this as providers that do not provide health care, such as Taxi Services, Durable Medical Equipment, and Respite Care |
| **BCBA** | Board Certified Behavioral Analyst |
| **BHT** | Behavioral Health Treatment |
| **CAQH** | Coalition for Affordable Quality Health Care |
| **CAP** | Capitation – the payment of a fee or grant to a doctor, school, or other person or body providing services to a number of people, such that the amount paid is determined by the number of patients, students, customers |
| **CHIP** | Children's Health Insurance Program |
| **CMHC** | Community Mental Health Center |
| **CMS** | Centers for Medicare and Medicaid Services |
| **COB** | Coordination of Benefits |
| **CPT** | Current Procedural Terminology |
| **DHSS** | Department of Health and Social Services |
| **DME** | Durable Medical Equipment |
| **DMS** | Department of Medicaid Services |
| **DOS** | Date of Service |
| **DRG** | Diagnosis Related Group |
| **EDI** | Electronic Data Interchange Application used to view claims, along with services rendered |
| **EFT** | Electronic Funds Transfer |
| **ERA** | Electronic Remittance Advice |
| **ETA** | Estimated Time of Arrival |
| **EPSDT** | Early and Periodic Screening Diagnosis and Treatment |
| **FFS** | Fee for Service |
| **FQHC** | Federally Qualified Health Center |
| **HCBS** | Home and Community Based Services |
| **HCFA ("hick-fa")** | Health Care Finance Administration - type of claim - HCFA 1500 forms. Typically used for physician or non-facility type services. |
| **HEDIS** | Healthcare Effectiveness Data and Information Set |
| **HHS** | U.S. Department of Health and Human Services |
| **HIPAA** | Health Insurance Portability and Accountability Act |

| | |
|---|---|
| **IPA** | Independent Physician Association |
| **JCAHO** | Joint Commission on Accreditation of Healthcare Organizations |
| **LOS** | Length of Stay |
| **LTCSS** | Long-Term Care Supports and Services |
| **LTSS** | Long-Term Services and Supports |
| **MCO** | Managed Care Organization |
| **MLR** | Medical Loss Ratio |
| **Non-Par** | Non-participating Provider |
| **NP** | Nurse Practitioner |
| **NPI** | National Provider Identification – 10-digit number assigned to physicians and/or groups |
| **NPPES ("N-pez")** | National Plan and Provider Enumeration System - free directory of all active National Provider Identifier (NPI) records |
| **OIG** | Office of the Inspector General |
| **PA** | Physician Assistant |
| **Panel** | Accepting New Members - other departments may frequently say "Panel" instead, both are correct |
| **PAR** | Participating Provider |
| **PCP** | Primary Care Provider |
| **PHI** | Protected Health Information |
| **PHO** | Physician Hospital Organization |
| **PMPM** | Per Member, Per Month |
| | |
| **POS** | Place of Service |
| **PPO** | Preferred Provider Organization |
| **PRTF** | Psychiatric Residential Treatment Facility |
| **QA** | Quality Assurance |
| **RHC** | Rural Health Clinic |
| **SNF ("sniff")** | Skilled Nursing Facility |
| **SQL ("see-kwool")** | Structured Query Language – a useful tool used to run reports and to look up data |
| **TANF** | Temporary Assistance for Needy Families |
| **TAT** | Turnaround Time |

| | |
|---|---|
| **TIN** | Tax Identification Number – 9-digit number assigned to sole proprietor physicians and groups |
| **TPA** | Third-Party Administrator |
| | |
| **UM** | Utilization Management |
| **UB-04** | Uniform Billing – billing claim form used typically to bill facility claims |