



Aetna Better Health[®] of Kansas

2024 Provider Manual

Provider Experience Department: **1-855-221-5656**



TABLE OF CONTENTS

Table of Contents.....	2
CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH OF KANSAS	8
Welcome.....	8
About Aetna Better Health of Kansas.....	8
About the Medicaid Managed Care Program	8
About this Provider Manual.....	9
CHAPTER 2: IMPORTANT CONTACT INFORMATION	10
CHAPTER 3: PROVIDER EXPERIENCE.....	14
Provider Training	14
Interested Providers	14
CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION	16
Provider Responsibilities Overview	16
Appointment Availability Standards	16
Members Presenting for Mental Health Services	18
Non-Emergency Medical Transportation Appointment Timeframes	19
HCBS Services	19
Telephone Accessibility Standards	21
Covering Providers	23
Verifying Member Eligibility.....	23
Availity Secure Web Portal	23
Preventive or Screening Services.....	24
Educating Members on their own Health Care	25
Emergency Services.....	25
Urgent Care Services	25
Primary Care Providers (PCPs).....	25
Specialty Providers.....	27
Specialty Providers or Primary Care Sites Acting as PCPs.....	27
Self-Referrals/Direct Access	28

Exceptions to Service Authorizations	28
Skilled Nursing Facility (SNF)/Nursing Facility (NF) Providers.....	28
Out-of-Network Providers.....	31
Provider Requested Member Transfer	31
Medical Records Review	31
Medical Record Audits.....	34
Access to Facilities and Records	34
Documenting Member Appointments	34
Missed or Cancelled Appointments	34
Documenting Referrals.....	34
Confidentiality and Accuracy of Member Records	34
Health Insurance Portability and Accountability Act of 1997 (HIPAA)	35
Member Privacy Rights.....	36
Member Privacy Requests	36
Advance Directives.....	37
Cultural Competency	37
Inclusive Patient Care.....	38
Individuals with Disabilities.....	39
Clinical Guidelines	39
Office Administration Changes and Training	40
Continuity of Care	40
Credentialing/Recredentialing.....	40
Licensure and Accreditation	45
Discrimination Laws	45
Financial Liability for Payment for Services.....	46
CHAPTER 5: COVERED AND NON-COVERED SERVICES.....	48
Covered Services.....	48
Value-added Benefits	51
Telemedicine.....	54
Spenddown	55
Long Term Services and Supports (LTSS).....	55

HCBS Services	55
Waiver Services	57
Medical Necessity.....	59
Emergency Services.....	59
Emergency Transportation.....	60
Non-Emergent Transportation	60
Laboratory Services – Lab Corp.....	60
Pharmacy Services.....	61
Vision Services – SKYGEN	61
Dental Services – SKYGEN.....	61
Interpretation Services.....	61
CHAPTER 6: BEHAVIORAL HEALTH.....	62
Mental Health/Substance Use Disorder Services.....	62
Availability.....	62
Referral Process for Members Needing Mental Health/Substance Use Disorder Assistance.....	62
PCP Role in Behavioral Health Services.....	62
Coordination between Behavioral Health and Physical Health Services.....	63
CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES.....	64
Member Rights.....	64
Member Responsibilities.....	65
Member Rights under Rehabilitation Act of 1973.....	66
CHAPTER 8: ELIGIBILITY AND ENROLLMENT	68
Our Members	68
Open Enrollment	68
ID Card	68
Sample ID Card.....	69
Verifying Eligibility.....	69
CHAPTER 9: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT	70
KAN Be Healthy (KBH) – EPSDT Specific Requirements	70
Periodicity Schedule.....	70
EPSDT Services.....	70

Identifying Barriers to Care.....	72
Educating Members about EPSDT Services	72
Provider Responsibilities in Providing EPSDT Services	72
Provider Monitoring.....	74
PCP Notification.....	74
Direct-Access Immunizations.....	74
Vision Services	75
Dental Services	75
Mental Health/Substance Use Disorder	75
CHAPTER 10: MEMBERS WITH SPECIAL NEEDS.....	76
Members with Special Needs	76
CHAPTER 11: SERVICE COORDINATION.....	79
CHAPTER 12: CONCURRENT REVIEW AND DISCHARGE PLANNING	84
Concurrent Review Overview.....	84
Neonatal Intensive Care Unit Coordination.....	84
Discharge Planning Coordination	85
Discharge from a Skilled Nursing Facility	86
CHAPTER 13: PRIOR AUTHORIZATION	87
Emergency Services.....	87
Post-stabilization Services	87
Services Requiring Prior Authorization	88
Exceptions to Prior Authorizations.....	88
Provider Requirements	88
How to request Prior Authorizations.....	89
Medical Necessity Criteria (Physical and Behavioral Health)	89
Timeliness of Decisions and Notifications to Providers and Members.....	90
Prior Authorization Period of Validation	91
Out-of-Network Providers.....	92
Notice of Action Requirements	92
Continuation of Benefits.....	93
Prior Authorization and Coordination of Benefits	94
CHAPTER 14: QUALITY MANAGEMENT.....	96

Overview	96
Identifying Opportunities for Improvement	97
Potential Quality of Care (PQoC) Concerns.....	99
Performance Improvement Projects (PIPs).....	99
Peer Review.....	100
Performance Measures	100
Satisfaction Survey	100
Member Satisfaction Surveys	100
Provider Satisfaction Surveys	101
External Quality Review (EQR).....	101
Provider Profiles.....	101
CHAPTER 15: PHARMACY MANAGEMENT	103
Pharmacy Management Overview.....	103
E-Prescribing.....	103
Formulary/Preferred Drug List (PDL).....	103
Quantity Level Limits (QLL)	104
Prior Authorization Process.....	104
Mail Order Prescription	105
CHAPTER 16: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)	107
Advance Directives.....	107
Proxy Directive	109
Instruction Directive	109
Patient Self-Determination Act (PSDA).....	110
Transportable Physician Orders for Patient Preferences (TPOPP)	110
CHAPTER 17: BILLING AND CLAIMS OVERVIEW.....	112
Billing and Claims Overview	112
Information on Billing and Claim Submission.....	113
Coding Overview	118
Claim Resubmission	121
Remittance Advice	122
CHAPTER 18: APPEAL AND GRIEVANCE SYSTEM	127

Member Appeal and Grievance System Overview.....	127
Member Grievance Process.....	128
Member Appeal Process.....	129
Provider Reconsiderations.....	133
Provider Appeals.....	133
Provider State Fair Hearing.....	135
Oversight of the Appeal and Grievance Processes.....	136
CHAPTER 19: FRAUD, WASTE, AND ABUSE	137
Fraud, Waste and Abuse.....	137
Special Investigations Unit.....	137
Reporting Suspected Fraud and Abuse.....	137
Fraud, Waste, and Abuse Defined.....	138
Elements to a Compliance Plan.....	140
Relevant Laws.....	141
Administrative Sanctions.....	142
Remediation.....	142
Exclusion Lists & Death Master Report.....	142
CHAPTER 20: MEMBER ABUSE AND NEGLECT	144
Mandated Reporters.....	144
Children.....	144
Vulnerable Adults.....	144
Reporting Identifying Information.....	145
Examinations to Determine Abuse or Neglect.....	145
Examples, Behaviors, and Signs.....	145

CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH OF KANSAS

[Back to
Table of
Contents](#)

Welcome

Welcome to Aetna Better Health of Kansas. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Kansans who need us most.

About Aetna Better Health of Kansas

For over 30 years, Aetna Medicaid has honed our approach to serving high-acuity, medically frail and low-income populations with diverse benefits. Our goal is to improve the functional status and quality of life for members, while providing budget predictability to our state partners. Our experience in implementing, managing, and caring for high-acuity Medicaid beneficiaries results in improved access to care, higher quality care in appropriate settings, and a simplified consumer experience in a culturally competent manner. We take seriously our responsibility as a steward of public programs.

Today, Aetna Medicaid serves more than 3 million members through Medicaid managed care plans. In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our most vulnerable members. While our programs and services continue to evolve and expand, our mission remains the same, building a healthier world by improving the lives and well-being of every member we are privileged to serve.

Experience and Innovation

We enhance member and provider satisfaction by using tools such as predictive modeling, service coordination, and state-of-the-art technology to achieve cost savings and help enrollees attain the best possible health through a variety of service models. We work closely and cooperatively with physicians, hospitals, and all other providers to achieve demonstrable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

About the Medicaid Managed Care Program

KanCare is the program through which the State of Kansas administers Medicaid. Launched in January 2013, KanCare is delivering whole-person, integrated care to more than 415,000 people across the state. The State of Kansas has contracted with us, as well as other managed care organizations (MCOs), to coordinate health care for all people enrolled in Medicaid.

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the State of Kansas. KDHE

maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health, and substance abuse, as well as operates the state hospitals and institutions.

About this Provider Manual

This Provider Manual serves as a guide to the policies and procedures governing the administration of Aetna Better Health and is an extension of and supplement to the Provider Agreement between Aetna Better Health and contracted practitioners and providers delivering health care service(s) to our members.

We retain the right to add to, delete, and otherwise modify this Manual. Revisions to this Manual reflect changes made to our policies and procedures updated at least annually. Revisions will be binding and will comply with any statutory, regulatory, contractual, and accreditation requirements. As policies and procedures change, we will let you know, at least 30 calendar days in advance about updates in the Provider Newsletter, via our website, electronically via email, and incorporated into subsequent versions of this Manual.

We are always looking to improve the usefulness of the tools and information we make available to our practitioners and providers, and we welcome your comments and feedback. You may e-mail comments/feedback and suggestions directly to:

ProviderExperience_KS@AETNA.com.

CHAPTER 2: IMPORTANT CONTACT INFORMATION

[Back to Table of Contents](#)

Aetna Better Health of Kansas

**9401 Indian Creek Parkway, Ste. 1300
Overland Park, KS 66210**

Department	Important Contact Information	Hours and Days of Operation
Aetna Better Health Provider Experience	<p><u>Phone:</u> 1-855-221-5656 (TTY: 711)</p> <p><u>Fax:</u> Toll-free Fax: 1-855-215-8760 Non-toll-free Fax: 1-959-282-8865</p> <p><u>Provider Relations Email:</u> ProviderExperience_KS@Aetna.com</p> <p><u>Availity Web Portal:</u> https://apps.availity.com/availity/web/public.elegant.login</p>	<p>Live agents available: Monday through Friday 8 AM - 5 PM Central Time, excluding State holidays</p> <p>Interactive voice response (IVR) system available: 24 hours per day / 7 days per week</p> <p>Availity Web Portal available: 24 hours per day, 7 days per week</p>
Aetna Better Health Behavior Health Services	<p><u>Phone:</u> 1-855-221-5656 (TTY: 711)</p> <p><u>Email:</u> AetnaBetterHealthKSCM@aetna.com</p>	<p>Live agents available: 24 hours per day, 7 days per week</p> <p>Interactive voice response (IVR) system available: 24 hours per day/ 7 days per week</p>
Aetna Better Health Member Services	<p><u>Phone:</u> 1-855-221-5656 (TTY: 711)</p> <p><u>Fax:</u> 1-959-282-8852</p> <p><u>Email:</u> MemberServices_KS@Aetna.com</p>	<p>Representatives available 24 hours per day, 7 days per week</p> <p>Interactive voice response (IVR) system available: 24 hours per day/ 7 days per week</p> <p>Interpreter services available for members</p>

<p>Aetna Better Health Service Coordination</p>	<p>1-855-221-5656 (TTY: 711) AetnaBetterHealthKSCM@aetna.com</p> <p>LTSS Email: AetnaBetterHealthKSHCBS_LTSS@AETNA.com</p>	<p>Service Coordinators available Monday through Friday 8 AM-5 PM Central Standard Time, excluding State holidays</p> <p>Interactive voice response (IVR) system available: 24 hours per day/ 7 days per week</p> <p>For urgent issues at all other times, call our after-hours area through the IVR system</p>
<p>Aetna Better Health Utilization Management</p>	<p><u>Phone:</u> 1-855-221-5656 (TTY: 711)</p> <p><u>Prior Authorization Fax:</u> 1-855-225-4102</p> <p><u>Concurrent Review Fax:</u> 1-855-225-4113</p> <p><u>Provider Portal Availability:</u> www.availity.com/healthplans *Select: Patient Registration Authorizations & Referrals</p>	<p>UM clinician available: Monday through Friday 8 AM-5 PM Central Standard Time, excluding State holidays</p> <p>Interactive voice response (IVR) system available: 24 hours per day/ 7 days per week</p> <p>For urgent issues at all other times, call our after-hours area through the IVR system</p>
<p>ProgenyHealth NICU Care Management and Utilization Review</p>	<p><u>Admission Notification Fax:</u> 1-888-767-0398</p> <p><u>Main Number and Peer to Peer Requests:</u> 1-888-832-2006</p> <p><u>UM Email:</u> ABHKS-UM@progenyhealth.com</p> <p><u>CM Email:</u> ABHKS-CM@progenyhealth.com</p>	<p>Direct contact information for the ProgenyHealth UM and CM Nurses will be provided once assigned to a member admitted to the provider's facility.</p>

Aetna Better Health Compliance Hotline (Mechanism for reporting Compliance and ethics issues for members, staff and providers including Fraud, Waste, or Abuse)	Phone: 1-866-275-7704 (TTY: 711)	24 hours per day/ 7 days per week through Voice Mail inbox
Aetna Better Health Special Investigations Unit (SIU) (Reporting Fraud, Waste, or Abuse)	Phone: 1-800-338-6361 (TTY: 711)	24 hours per day/ 7 days per week
CVS Caremark Pharmacy Network Help Desk	Phone: 1-844-234-8268	24 hours per day/ 7 days per week

Aetna Better Health Partners	Phone Number & Website
Dental – SKYGEN	1-855-918-2256 (Providers) 1-855-918-2257 (Members) www.SKYGEN.com
Vision – SKYGEN	1-855-918-2258 (Providers) 1-855-918-2259 (Members) www.SKYGENusa.com
Radiology and Pain Management – Evicore	1-888-693-3211 www.evicore.com
Non-Emergent Transportation – Access2Care Provider Line	1-866-252-5634
Lab and Diagnostic Services – Lab Corp	www.labcorp.com
Clearinghouse: Change Healthcare	1-877-667-1512 www.changehealthcare.com
Clearinghouse: Office Ally Inc.	1-360-975-7000 www.officeally.com
ProgenyHealth’s Neonatal Intensive Care Coordination (UM and CM services)	1-888-832-2006 www.progenyhealth.com

State & Federal Contact Information	Phone Number & Website
Kansas Department of Health and Environment (KDHE)	1-785-296-1500 KDHE: www.kdhe.ks.gov KanCare: www.kancare.ks.gov

Kansas Department for Aging and Disability Services (KDADS)	1-785-296-4986 (KDADS): www.kdads.ks.gov
Kansas Medical Assistance Program (KMAP) - Enrollment and Contract Status	1-800-933-6593 Monday through Friday 8 AM-5 PM Central time, excluding State holidays https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate
Kansas Relay (TTY)	711
Kansas Tobacco Quitline "KanQuit"	1-800-QUIT-NOW (784-8669) www.KSquit.org

CHAPTER 3: PROVIDER EXPERIENCE

[Back to Table of Contents](#)

Our Provider Experience department functions as a liaison between the Health Plan and the provider community. The Provider Experience staff is available and ready to support our provider community with assistance in several areas including but not limited to:

- Contract status
- Credentialing and recredentialing questions
- Provide information on how to update location/address changes via the KMAPs system
- View recent updates
- Locate forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- How to submit a prior authorization
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Provide information on how to update Tax ID or National Provider Identification (NPI) Number change via the KMAPs system
- Review claims or remittance advice

Our Provider Experience department supports network development and contracting with multiple functions, including evaluation of the provider network and compliance with regulatory network capacity standards. Our staff creates and develops provider communication materials, including the Provider Manual, Periodic Provider Newsletters, Bulletins, Fax/E-mail blasts, website notices, the Provider Orientation Kit, as well as attends provider conferences and meetings throughout the year.

Provider Training

We offer a variety of provider educational training opportunities to our network providers. Our trainings give you the information and tools you need to serve our members as efficiently as possible. Please contact a Provider Experience representative if you and your staff would like additional training. Your Provider Experience representative will be happy to set up a training that will fit your needs.

Interested Providers

If you are interested in applying for participation with us, you must first register in the State's provider enrollment system. This requirement is regulated by Title 42 Code of Federal Regulations (CFR) §438.602(b) (1). This rule applies to all provider types and specialties and

is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

To register, please visit the website below to locate the Kansas Medicaid Assistance Program (KMAP) enrollment page.

Kansas Medical Assistance Program (KMAP) - Enrollment and Contract Status	1-800-933-6593 Monday through Friday 8 AM-5 PM Central time, excluding State holidays https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate
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Contacting your Provider Experience Representative

Our Provider Experience team is separated into three (4) teams based on provider type:

- Medical (Hospital and Ancillary providers)
- Behavioral Health (BH)
- Home Community Based Services (HCBS) and Long-Term Services Support (LTSS).
- Skilled Nursing Facilities

The Provider Experience team members contact information, and their responsible territory can be found on our website under the “For Providers” heading or by following the link:

www.AetnaBetterHealth.com/Kansas/Providers

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

[Back to Table of Contents](#)

Provider Responsibilities Overview

This section outlines general provider responsibilities; however, we include additional responsibilities throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. You are contractually obligated to adhere to and comply with all terms of Aetna Better Health's Medicaid programs; your Provider Agreement; and requirements outlined in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than your Provider Agreement and this manual.

You must cooperate fully with state and federal oversight and prosecutorial agencies. This includes but is not limited to: Kansas Department of Health and Environment (KDHE), Kansas Department of Aging and Disability Services (KDADS), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS), and the U.S. Attorney's Office.

You must also confirm the use of the most current diagnosis, treatment protocols, and standards established by the State of Kansas and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals on the basis race, color, national origin, age, disability, and sex, except where medically indicated.

Appointment Availability Standards

We require that you schedule appointments for eligible members in accordance with minimum appointment availability standards based on the acuity and severity of the presenting condition in conjunction with the member's past and current medical history. Our Provider Experience department routinely monitors compliance and seeks Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. You are contractually required to meet the timely access to care and services below, considering the urgency of and the need for the services. Additionally, in-office wait times must not exceed forty-five (45) minutes from the time of the scheduled appointment.

The following grid considers the timeframes from KDHE and National Committee for Quality Assurance (NCQA) regulations.

Provider Type	Emergency Services	Urgent Care	Preventative & Routine Care	Wait Time in Office Standard	After-Hours
PCP	Same Day and/or refer to emergency room as necessary	Within 48 hours	Within 3 weeks	No more than 45 minutes	An after-hours phone call from an appropriate practitioner within an hour of the member contacting the organization.
Specialty Referral (Includes high-volume specialty care)	Same Day	Within 48 hours of referral	Within 30 calendar days	No more than 45 minutes	
Members presenting for SUD Services	Immediately	Assessment within 24 hours; services rendered within 24 hours of assessment	Assessment within 14 calendar days	Treatment within 24 hours of assessment; When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care.”	Assessment and admission to treatment no later than 14 calendar days of making request for Assessment. If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to

Provider Type	Emergency Services	Urgent Care	Preventative & Routine Care	Wait Time in Office Standard	After-Hours
					the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment.”

Members Presenting for Mental Health Services

- **Members Discharged from Inpatient Care**

Providers must encourage member attendance and follow-up appointments after discharge within 1-10 days. The timeframe begins the day the member is discharged.

- **Members not Admitted for Inpatient Care for Mental Health Services**

Providers must follow up with any member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.

Provider Type	Emergency Services	Non-Life Threatening (Urgent Care)	Urgent (no immediate danger)	Preventative & Routine	After Hours	Wait Time in Office Standards
Members presenting for Mental Health Services	Immediately	Assessment within 6 hours	Members with non-urgent needs shall be assessed within fourteen (14) business days of the date the services are requested	New patient initial Visit within 10 business days of request for services	24 hours per day/ 7 days per week	NCQA: No more than 45 minutes

- Non-life-threatening urgent: There is no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate resulting in a risk to self or others:
 - Extreme anxiety
 - Parent child issues
 - Passive suicidal ideation
 - Excess drug or alcohol usage

- Urgent – no immediate danger: There is no immediate danger to self or others and/or if the situation is not addressed within 14 business days, it may escalate resulting in a risk to self or others:
 - Follow-up to a crisis stabilization
 - Escalating depression
 - Escalating anxiety
 - Escalating drug/alcohol usage
 - Escalating behavioral issues in children

Non-Emergency Medical Transportation Appointment Timeframes

Aetna Better Health contractually requires the following appointment access standards for transportation for physical, behavioral health and LTSS services. Transportation must arrive at the provider location:

- No sooner than 1 hour before the member’s appointment
- At least 15 minutes prior to the member’s appointment time
- No more than 1 hour after the appointment for return transportation

Please note that follow-up to Emergency Department (ED) visits must be in accordance with ED attending provider discharge instructions.

HCBS Services and the respective service initiation timeframe

Note: For HCBS, all business daytime periods are measured from the time of the signed person-centered service plan by members (or legal guardians), applicable providers, and the service care coordinator.

Description of Timely Access Standards to Initiation of HCBS Services:

21 Calendar Days
Services Delivered In-Home
Services Requiring RN Skilled Provider (our assumption is that this provider type is more readily available than others)
45 Calendar Days
Services Delivered at a Fixed Site for which Members must travel to a location
Services Requiring Allied Health/Therapist/Other Skilled Provider
Self-Directed Services
60 Calendar Days
High-Cost, Single Unit Services (i.e., assistive services, assistive technology)

Timely Access Standards for Individual HCBS and BH Services:

Service and Code(s)	Number of Days to Receive First Service
HCBS Services	
Adult Day Care-S5101 (1-5 Hours), S5102 (5+ Hours)	21 calendar days
Attendant Care-T1019/HK	21 calendar days
Behavior Therapy-H0004	21 calendar days
Cognitive Rehabilitation-97532	21 calendar days
Comprehensive Support-S5135 (agency directed)	21 calendar days
Enhanced Care Service -T2025 (formerly sleep cycle support)	21 calendar days
Financial Management T2040 U2	21 calendar days
Home Delivered Meals -S5170	21 calendar days
Home Telehealth -S0315 (install)	21 calendar days
Home Telehealth -S0317 (rental)	21 calendar days
Intermittent Intensive Medical Care (RN level) -T1002	21 calendar days
Medical Alert Rental -S5161	21 calendar days
Medical Respite Care (TA waiver), Respite Care (AU waiver)-T1005	21 calendar days
Medication Reminder-S1505/UB (dispenser)	21 calendar days
Medication Reminder-T1505 (install)	21 calendar days
Medication Reminder-S5185 (call)	21 calendar days
Nursing Evaluation Visit (FE waiver)/Health Maintenance Monitoring	21 calendar days
Overnight Respite Care-H0045	21 calendar days
Personal Care Services-(agency) S5125 U9	21 calendar days
Personal Care Services-(agency) T1004	21 calendar days
Personal Emergency Response System (install)-S5160	21 calendar days
Personal Emergency Response System (rental)-S5161	21 calendar days
Short-Term-S5150 (provider managed)	21 calendar days
Specialized Medical Care SMC-T1000 (LPN), /T100 TD (RN -IDD only)	21 calendar days
Supported Employment-H2023	21 calendar days
Supportive Home Care (agency) S5125/U6	21 calendar days
Transitional Living Skills-H2014	21 calendar days
Wellness Monitoring-S5190	21 calendar days
Wraparound Facilitation-H2021	21 calendar days -in-home 45 calendar days -site-based
Comprehensive Support-S5135/UD (self-directed)	45 calendar days
Day Supports-T2021	45 calendar days
Family Adjustment Counseling-S9482 (individual	45 calendar days

rate)	
Family Adjustment Counseling-S9482/HQ (group rate)	45 calendar days
Occupational Therapy-G0152	45 calendar days
Oral Health Services-DDDDD	45 calendar days
Parent Support and Training-T1027 (individual rate)	45 calendar days
Parent Support and Training (group rate)-T1027/HQ	45 calendar days
Parent Support and Training (group rate)-S5110-TJ	45 calendar days
Parent Support and Training (individual rate)-S5110	45 calendar days
Personal Care (self-direct)-S5125 U6	45 calendar days
Personal Care (self-direct)-S5125 UB	45 calendar days
Personal Care (self-direct) T1019	45 calendar days
Personal Care Services-(self-directed, formerly Personal Assistant	45 calendar days
Physical Therapy-G0151	45 calendar days
Professional Resource Family Care-S9485	45 calendar days
Residential Supports-T2016	45 calendar days
Speech Language Therapy-G0153	45 calendar days
Assistive Services-S5165 (also called Home Modification for TA only)	60 calendar days
Assistive Technology-T2029	60 calendar days

Telephone Accessibility Standards

You are responsible for after-hours coverage either by being available or having on-call arrangements in place with other qualified, participating Aetna Better Health providers for the purpose of rendering medical advice and determining the need for emergency or other after-hours services including authorizing care and verifying member enrollment with us.

It is our policy that providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent, or emergent health care issues is held to the same accessibility standards regardless of if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

A published after-hours telephone number must be available to members to enable access to care 24 hours per day, 7 days per week. In addition, we encourage you to offer open access scheduling, expanded hours, and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We routinely measure your compliance with these standards as follows:

- Our medical and provider management teams will evaluate emergency room data to determine if there is a pattern where a PCP failed to comply with after-hours access or if a member may need service coordination intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care on a monthly basis to

determine if a PCP is failing to comply.

In addition, you must comply with telephone protocols for all the following situations:

- Answering member telephone inquiries in a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

We consider a telephone response acceptable/unacceptable based on the following criteria:

Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail
- The answering service either:
 - Connects the caller directly to the provider
 - Contacts the provider on behalf of the caller and the provider returns the call
 - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the provider/covering provider

Unacceptable:

- The answering service:
 - Leaves a message for the provider on the PCP/covering provider's answering machine
 - Responds in an unprofessional manner
- The provider's answering machine message:
 - Instructs the caller to go to the emergency room for care, regardless of the exigencies of the situation, without enabling the caller to speak with the provider for non-emergent situations
 - Instructs the caller to leave a message for the provider
- No answer
- Listed number is no longer in service
- Provider is no longer participating in the Aetna Better Health network
- On hold for longer than five minutes
- Telephone lines are persistently busy despite multiple attempts to contact the provider

Hours of operation must be convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured, or public fee-for-service individuals.

In the event that telephone accessibility standards are not met, a Provider Experience representative will be in contact to discuss the deficiency, provide additional education, and work to correct the barrier to care.

Covering Providers

Providers must notify our Provider Experience department if a covering provider is not contracted or affiliated with our network. Notification must occur in advance of providing authorized services. Reimbursement to a covering provider is based on the Aetna Better Health fee schedule. Failure to notify our Provider Experience department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Providers must verify a member's assigned provider prior to rendering primary care services. We **do not** reimburse providers for services rendered to ineligible members who lost eligibility.

You can verify member eligibility through one of the following ways:

- KMAP: The KMAP website provides information to Medicaid beneficiaries and providers. If you are enrolled in KanCare or providing services to a KanCare member, links for the individual plans are under KanCare Health Plans. You can find the KMAP website at the following link: <https://www.kmap-state-ks.us/>
- Availity Web Portal : Providers can verify current member eligibility on the Availity Web Portal.
- Telephone Verification: Eligibility for members can be verified by calling Member Services at **1-855-221-5656**. To protect member confidentiality, providers are asked to confirm their identity with the name, tax ID, or NPI. Providers are asked for at least three pieces of identifying information, such as the member's name, identification number, date of birth, and address before any eligibility information is released.

Availity Secure Web Portal

The Availity Secure Portal is a web-based platform that allows us to communicate member health care information directly with providers and in real-time. Providers can perform many functions within this web-based platform. The following information is available on Availity:

- Member Eligibility Search – Verify current eligibility of one or more members
- Panel Roster – View the list of members currently assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. We display only claims associated with the user's account provider ID
- Remittance Advice Search – Search for a PDF version of your provider remittance advice.
- Provider Auth/Referral Dashboard Tool – Allows provider to view the status of a previously submitted electronic authorization as well as submit an authorization request on-line

Population Health Platform

The Population Health Platform is a web-based tool available to select providers who participate in value-based agreements Aetna Better Health and are supported by that enables access to member specific data. The strength of the tool resides in the system's ability to timely expose actionable clinical data and other critical pieces of the care record. Available member information includes service and costs as per claims history data, the member's ED and hospitalization risk, HEDIS gaps in care, the care management team's plan of care and other relevant clinical data. The tool also enables near-real awareness of and access to HIE submitted admissions, discharges, and ED visit data.

Specific data and usage may include:

- The ability to view and print a member's service plan
- Ability to view a member's profile, which contains:
 - Member's contact information
 - Member's demographic information
 - Up to one year's claims history
 - HEDIS gaps in care
 - Member's care team: Primary care provider, specialists, and other care team members (from claims), health plan care manager
 - Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level
 - High-risk indicator (based on existing information, past utilization, and member rank as compared to the total plan population)
 - Member reported and documented conditions and medications (including Over the Counter (OTC), herbals, and supplements)
- The ability to create a registry of gaps in care/care considerations for entire Aetna Better Health population
- Utilize ADT and clinical data to support transition of care management

Providers who have access to the platform, receive education and training and ongoing support for using the system.

Continuity for Behavioral Health Care

The PCP provides basic behavioral health services and refers the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Preventive or Screening Services

Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations and health screenings

- Well woman visits (female members may go to an obstetrician/gynecologist for a well woman exam once a year without a referral)
- Dental screenings and topical application of fluoride

Educating Members on their own Health Care

Aetna Better Health does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise the member on:

- The member's health status and medical care or treatment options including any self-administered alternative treatments
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his/her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

Providers may freely communicate with members on items such as these regardless of benefit coverage limitations.

Emergency Services

We do not require authorizations for emergency services. If a provider cannot provide services to a member who needs urgent or emergent care, or if the member calls after hours, providers should refer the member to the closest emergency room department or in-network urgent care.

Urgent Care Services

As the provider, you must serve the medical needs of our members meeting all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases).

Periodically, Aetna Better Health reviews unusual urgent care and emergency room utilization. We review trends, which may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)

The primary role and responsibilities of PCPs include, but are not limited to:

- Providing or arranging for urgent covered services as defined in your contract, including emergency medical services, to members on a 24 hours per day, 7 days per week basis
- Providing primary and preventive care that includes, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable
- Acting as the member's advocate

- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers
- Maintaining the member's medical record
- Conducting office visits during regular office hours
- Office visits or other services during non-office hours as determined to be medically necessary
- Response to phone calls within a reasonable time and on an on-call basis 24 hours per day, 7 days per week (refer to the appointment available requirements in this chapter)

PCPs, in their care coordination role, serve as the referral agent for specialty and referral treatment and services provided to members assigned to them, and attempt to verify that coordinated, quality care is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, specialty providers, or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with our Prior Authorization department regarding prior authorizations for members
- Conducting follow-up (including maintaining records of services provided) for referral services rendered to their assigned members by other providers, specialty providers, or hospitals
- Coordinating medical care for the programs the member is assigned to, including at a minimum:
 - Oversight of drug regimens to prevent negative interactive effects
 - Follow-up for all emergency services
 - Coordination of inpatient care
 - Coordination of services provided on a referral basis
 - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs

PCPs are responsible for establishing and maintaining hospital admitting privileges sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

PCPs should only refer members to Aetna Better Health network specialists. If the member requires specialized care from a provider outside our network, PCP will need to obtain a prior authorization.

Aetna Better Health (ABH) encourages pediatricians to serve as PCPs for eligible children.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health participating specialist. Specialists coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers a member to a different specialist or provider, the original specialist must share their records, upon request, with the referred-to provider or specialist. The sharing of documentation occurs with no cost to the member, other specialists, or other providers.

Specialty Providers Acting as PCPs

In limited situations, a member may select a physician specialist to serve as his/her PCP. In these instances, the specialist or PCS must be able to demonstrate the ability to provide comprehensive primary care. A member may request a specialist or PCS to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period of time and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex gerontology/oncology conditions, cystic fibrosis, etc.)
- When a member's health condition is life threatening, degenerative, or disabling in nature to warrant a specialist serving in the PCP role
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship developed over time leaving the member vulnerable or at risk for not receiving proper care or services

Aetna Better Health's Chief Medical Officer (CMO) coordinates efforts to review the request for a specialist to serve as PCP. The CMO has the authority to make the final decision to grant PCP status, taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in this Provider Manual, with respect to those members. This includes arranging for coverage 24 hours per day, 7 days per week.

PCP Panel Size

To locate panel size requirements or if there is a need to adjust the panel size, please log into the KDHE KMAP enrollment system: <https://portal.kmap-state-ks.us/publicpage>

Self-Referrals/Direct Access

Members may refer themselves to certain practitioners/providers including specialists for specific services identified in the member's benefit plan, Member Handbook, or in state or federal regulations. For example, we do not restrict a member's access to emergency services and do not require prior authorization or referral. Additionally, we do not restrict a member in his/her choice of health care practitioner or provider for family planning services.

Note: If a provider refers a member to a provider of a non-covered service, the provider must inform the member of his/her obligation to pay for such non-covered services and the member must sign a form stating they are aware that they must pay for the services.

Members have the right to receive a second opinion and we provide members information on how to obtain a second opinion. Aetna Better Health maintains a second opinion process as part of the Utilization Management program. Second opinions may be accessed by the member as an option for the diagnosis and treatment of serious chronic conditions, such as cancer or behavior/mental illness, and for elective surgical procedures. Access to a second opinion is not based on a diagnosis. If the member uses in-network practitioners/providers, no prior authorization or referrals are required to obtain a second opinion. Should a member wish to receive a second opinion there is no cost to the member whether the practitioner/provider is in- or out-of-network. A member may use out of network practitioners/providers if the network is limited in the specialty for which the opinion is requested if the plan is unable to provide an in-network option.

Aetna Better Health provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

Exceptions to Service Authorizations

The following services do not require authorization, whether furnished by a network or out-of-network provider or practitioner. Regardless of Network participation, all providers who render services to KS Medicaid member must be enrolled in the State's Medicaid Program.

Members may self-refer to:

- Emergency services
- Family planning services

Skilled Nursing Facility (SNF)/Nursing Facility (NF) Providers

Skilled Nursing Facilities (SNFs)/Nursing Facilities (NFs) provide inpatient skilled nursing care and related services to members who require medical, nursing, or rehabilitative services but do not provide the level of care or treatment available in a hospital or require daily care from a physician.

Members enrolled in the state's long-term services and supports (LTSS) program and whose home is considered the NF (long-stay) are often assigned a "patient liability", also

knowns as a “share of cost,” and must contribute this assigned amount to the cost of their NF care. The SNF/NF must collect this assigned amount from the member. When the SNF/NF submits their claim for a NF resident, the patient liability amount will be subtracted from the payment made by the health plan to the SNF/NF.

LTSS and non-LTSS members admitted for a subacute or SNF stay (short-term stay) from their home or hospital generally will not have an assigned patient liability that has to be paid to the SNF/NF.

Long Term Care Providers

Long-term care providers are responsible for providing services in accordance with the accepted community standards of care and practices. The long-term care provider is responsible for verifying member eligibility prior to providing services.

When a long-term care provider refers the member to a different long-term care provider, the original long-term care provider must share the member’s records, upon request, with the appropriate long-term care provider. The sharing of documentation occurs with no cost to the member, other long-term care provider, or other providers.

Home and Community Based Services (HCBS)

Our service coordinators are available to partner with the HCBS providers to collaborate on a comprehensive care plan for our members. Home and Community Based Services must work with our service coordinators to ensure their services will be paid. Service Coordinators complete face-to-face assessments with our members. Based on the assessment and the service planning process with the member, Service Coordinators identify the appropriate services to meet the member’s functional needs including determining which network provider may be available to provide services to the member in a timely manner. Upon completion, the Service Coordinators create authorizations for the selected provider and fax/e-mail these authorizations accordingly. Service Coordinators also follow up with the member the day after they received the services to confirm the selected provider started the services as authorized.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not bill for any days between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Caregivers are not allowed to bill for time with a member when services were not performed. This is also true for any in-home service.

Personal assistants and community agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the personal assistant and community agency will be required to pay back any monies paid by

Aetna Better Health. We do conduct periodic audits to verify compliance with billing requirements.

Home and Community Based Services (HCBS) in Assisted Living Facilities

Providers must offer HCBS waiver members residing in assisted living facilities and other residential care facilities services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms
- Roommate for semi-private rooms
- Locking door to living unit
- Access to telephone and length of use
- Eating schedule
- Participation in facility and community activities

Ability to have:

- Unlimited visitation
- Snacks as desired

Ability to:

- Prepare snacks as desired Maintain personal sleeping schedule

Facilities must collect room and board fees from members (includes alternative residential settings). Room and board fees include but are not limited to:

- Debt service costs
- Maintenance costs
- Utilities costs
- Food costs (includes three meals a day or any other full nutritional regimen)
- Taxes
- Boarding costs (includes room, hotel, and shelter-type of expenses)

Federal regulations prohibit Medicaid from paying room and board costs.

Please note that Aetna Better Health service coordinator completes the room and board agreement at time of placement:

- The room and board agreement identifies the level of payment for the setting, placement date, and room and board amount the member must pay, and the Aetna Better Health Service Coordinator completes it at the time of placement.
- The room and board amount may periodically change based on a member's income.
- The Service Coordinator completes the Room and Board Agreement form at least once a year or more often if there is a change in income.

Home and Community Based Services (HCBS) providers may not submit claims when the member has been admitted to a hospital, rehabilitation facility, or nursing facility. The day of

admission or discharge is allowed, but the days in between are not covered including charges such as medical alert system. Providers submitting claims for the days in between may be subject to a Corrective Action Plan (CAP) for improper billing.

Out-of-Network Providers

When a contracted provider is not able to serve a member with a special need for services, Aetna Better Health may authorize services through an out-of-network provider agreement. Our Medical Management team arranges care by authorizing services to an out-of-network provider and facilitating transportation through our own medical transportation program when there are no providers that can meet the member's special need available in a nearby location. If needed, our Provider Contracting department negotiates a Single Case Agreement (SCA) for the service and refers the provider to our Network Development team for recruitment to join the provider network. We may transition the member to a network provider when the treatment or services have been completed or the member's condition is stable enough to allow a transfer of care.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health member to leave the practice. Such requests cannot be based solely on the member filing a grievance, an appeal, or a request for a Fair Hearing or other action by the member related to coverage, high utilization of resources, or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

1. The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
**Aetna Better Health of Kansas
Provider Experience Manager
9401 Indian Creek Parkway, Ste. 1300
Overland Park, KS 66210**
2. The provider must support continuity of care for the member by giving a 30-calendar day notice and opportunity to make other arrangements for care.
3. Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, we will work with the member to inform him/her on how to select another PCP.

Medical Records Review

Aetna Better Health adopted our standards for medical records from NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our provider network. Below is a list of our medical record

review criteria. We require consistent organization and documentation in patient medical records as a component of our Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner to permit effective patient care and quality review. Providers must make records pertaining to our members immediately and completely available for review and copy by KDHE and federal officials at the provider's place of business, or forward copies of records to us or KDHE upon written request without charge.

Medical records must reflect the various aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner, and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are minimum medical record documentation and coordination requirements:

- Member identification information must appear on each page of the medical record
- Documentation of identifying demographics including the member's name, address, telephone number, employer, identification number, gender, gender identity, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Compliance with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to, obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, surgeries/operations, illnesses, accidents, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received
- Immunization records (recommended for adult members if available)
- Dental history, if available, and current dental needs and services
- A working diagnosis, as well as a final diagnosis, and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.
- Documentation of individual visit must provide adequate evidence of, at a minimum:
 - History and physical examination – Appropriate subjective and objective information is obtained for the presenting complaints

- Plan of treatment
- Diagnostic tests
- Therapies and other prescribed regimens
- Follow-up forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof
- Other aspects of patient care, including ancillary services
- Providers retain fiscal records relating to services rendered to members, regardless of whether the records have been produced manually or by computer.
- Drugs prescribed as part of treatment, including quantities and dosages. If a prescription is called in to a pharmacist, the prescriber's record has a notation to the effect.
- Documentation, initialed by the member's PCP, to signify review of:
 - Diagnostic information including:
 - Laboratory tests and screenings
 - Radiology reports
 - Physical examination notes
 - Other pertinent data
- Reports or referrals from consultations and specialists, emergency/urgent care
- Hospital discharge summaries for:
 - Hospital admissions that occur while the patient is enrolled in Aetna Better Health
 - Admissions as necessary
- Behavioral health referrals and services provided, as applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history
- Documentation as to whether an adult member has completed an advance directive and location of the document. (Kansas advance directives include Living Will, Health Care Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for releases of information and subsequent releases
- Documentation that diagnostic, treatment, and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care
- Entries are signed and dated by the responsible licensed provider. The responsible licensed provider countersigns care rendered by ancillary personnel. Alterations of the record are signed and dated.
- Provider identification on all entries

- The record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Record Audits

Aetna Better Health, KDHE, and CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, for administrative responsibilities, or for quality-of-care issues. Providers must respond to these requests promptly within 14 days of request. Medical records must be made available upon request and free of charge.

Access to Facilities and Records

We require providers to retain and make available all records pertaining to any aspect of services furnished to a member through their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of 10 years from the date of service
- 10 years after final payment is made under the provider's agreement and all pending matters are closed

Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record.

Missed or Cancelled Appointments

Providers must:

- Document in the member's medical record and follow-up on, missed or canceled appointments, including missed EPSDT appointments.
- Conduct affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards.
- Notify our Member Services department when a member continually misses appointments.

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists, within our network. Providers must follow the policies for emergency room care, second opinion, and noncompliant members.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our providers must:

- Maintain accurate medical records and other health information
- Help verify timely access by members to their medical records and other health information
- Abide by all federal and state laws regarding confidentiality and disclosure of behavioral health records, medical records, other health information, and member information

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

HIPAA contains many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA contains established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

We require providers to safeguard and maintain the confidentiality of data encompassed in medical records as well as confidential provider and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA
- Have a patient sign-in sheet at the front desk
- Keep patient records, papers, and computer monitors out of view
- Have electric shredder or locked shred bins available

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that includes:
 - The individual's past, present, or future physical or behavioral health or condition
 - The provision of health care to the individual
 - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual

- Many common identifiers (e.g., name, address, birth date, Social Security Number)
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
- Release of data to third parties requires advance written approval from the department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or Q&A, please visit the following site at <http://aspe.hhs.gov/admsimp/final/pvcguide1.htm>

Provider must follow both required and voluntary provision of medical records consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations www.hhs.gov/ocr/privacy/.

Member Privacy Rights

Aetna Better Health's privacy policy states that members are afforded privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements.

Our policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise their privacy rights through privacy requests, including:

- Making information available to members or their representatives about our practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests
- Documenting requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications

- Receive a Notice of Privacy Practices

The member or member's authorized representative may make a privacy request. A member's representative must provide documentation or written confirmation that he/she is authorized to make the request on behalf of the member or the deceased member's estate.

Advance Directives

We require providers to comply with federal and state law regarding advance directives for adult members. Providers must prominently display the advance directive in the adult member's medical record. Provider requirements include:

- Providing written information to adult members regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections)
- Documenting in the member's medical record whether the adult member has been provided the information and whether an advance directive has been executed
- Provide Aetna with a copy of the member's advance directive
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care

Cultural Competency

Aetna Better Health of Kansas regards cultural competency as a process in which we strive for the ability to effectively and respectfully bridge differences between one's own culture and the culture of others. Cultural competency refers to the practices and behaviors that ensure that all members receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a member's characteristics. Aetna Better Health is responsive to members' health literacy needs. Health literacy is the degree to which individuals have the capacity to obtain, understand and repeat back health information and services needed to make appropriate health decisions. In this way, members feel like they have been understood and that their beliefs, values, and behaviors are considered.

Aetna Better Health is committed to following the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and requires our providers to commit to the same. Aetna Better Health complies with applicable federal civil rights laws and do not discriminate against members based on race, color, national origin, age, disability or sex, except where medically indicated, or any other basis that is prohibited by law. Aetna Better Health expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds for all members including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- Those experiencing homelessness or who are at risk of being homeless
- Those with physical, intellectual, or developmental disabilities

Aetna Better Health of Kansas reviews provider satisfaction and CAHPS surveys to ensure culturally competent services are being provided and places providers on a corrective action plan and/or additional training for their actions related to complaints, grievances, audits, and other reports indicating potential problems.

Providers and their office staff are responsible for:

- Ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members
- Ensuring that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members
- Honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds. For additional questions, please contact us directly.
- Responding to member's health literacy needs.

We developed effective provider education that encourage respect for diversity, foster skills that facilitate communication within different cultural groups, and explain the relationship between cultural competency and health outcomes. We provide information on our member diversity, including the various cultural, racial, and linguistic challenges our members may experience, as well as methods for responding to those challenges.

Providers receive education about important topics such as:

- The reluctance of certain cultures to discuss behavioral health issues and the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices)
- The barriers created by health illiteracy and the need to provide members with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Inclusive Patient Care

In accordance with federal, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is required to verify that members with LEP have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons with LEP are often excluded from programs they are eligible for, experience delays, denials of services, or receive care & services based on inaccurate or incomplete information.

We require providers to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, we make our telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, our Member Services Representatives assist the member via a conference call to communicate in the member's native language.
 - For outgoing calls, Member Services staff dials the language interpretation service using an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, our staff (e.g., Service Coordinators) can conference in an interpreter to communicate with a member in his/her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call us to link with an interpreter.

We provide alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's offices, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity; or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office inspections are conducted by our Provider Experience staff to verify that our providers are compliant.

Clinical Guidelines

Aetna Better Health has Clinical Guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services, and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member

- Constitute procedures for or the practice of medicine by the party distributing the guidelines
- Guarantee coverage or payment for the type or level of care proposed or provided

Clinical Guidelines are available on our website at www.AetnaBetterHealth.com/Kansas

Office Administration Changes and Training

Providers are responsible to notify our Provider Experience department of any changes in professional staff at their offices (physicians, physician assistants, or staff practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience department to schedule staff training.

Continuity of Care

We require providers terminating their contracts without cause to continue to treat our members until completing the treatment course or care is transitioned. An authorization may be necessary for these services. You may also contact our Service Coordination department for assistance.

Credentialing/Recredentialing

Aetna Better Health has partnered with KDHE to provide a seamless credentialing process for providers and practitioners. Prior to participation, the state requires all providers and practitioners to enroll through KMAP. If you indicate that you would like to enroll with Aetna Better Health, we will contact you and begin the credentialing process.

We use current NCQA standards and guidelines for the review, credentialing, and re-credentialing of providers as well as the State of Kansas credentialing process. Aetna Better Health requires providers to complete the application found on the State of Kansas Enrollment portal at <https://portal.kmap-state-vks.us/ProviderEnrollment/EnrollmentCreate> and ensure their information is submitted to Aetna Better Health of Kansas.

All new practitioners, (with the exception of hospital-based practitioners) including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing and Performance Committee.

Providers and practitioners are re-credentialed every three years and must complete the required reappointment application. We also require updates on malpractice coverage, state medical licenses, and DEA certificates. During the credentialing and re-credentialing process, we verify that a home-like environment and community integration exists in facilities they intend to contract with as well as in existing network assisted living facilities (ALFs).

Council for Affordable Quality Healthcare ProView

Aetna Better Health uses current NCQA standards and guidelines for the review,

credentialing, and recredentialing of practitioners and uses the Council for Affordable Quality Healthcare (CAQH) ProView. CAQH is a nonprofit alliance of America's leading health plans. CAQH ProView allows practitioners to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends providers a reminder every 90 days to re-attest to their information.

Health plans and hospitals designated by providers obtain application information directly from the CAQH database. Aetna Better Health uses CAQH ProView to obtain credentialing information; CAQH Proview is compliant with state-required credentialing applications. This eliminates the need for multiple organizations to contact the provider for the same information. CAQH gathers and stores detailed data for more than 1 million providers nationwide. Practitioners enrolled with KMAP must also ensure that demographic information is up to date with KMAP.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital-based providers) including practitioners joining an existing participating practice with Aetna Better Health of Kansas, must complete the credentialing process and be approved by the Credentialing Committee. Aetna Better Health of Kansas doesn't discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments.

Recredentialing Individual Practitioners

Aetna Better Health recredentials practitioners on a regular basis (every 36 months based on state regulations) to make sure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the provider contract can occur if a provider misses the 36-month timeframe for recredentialing. Aetna Better Health of Kansas doesn't discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or provider sanctions, or loss of license to help manage potential risk of sub-standard care to our members.

The Credentialing Verification Organization performs Primary Source Verification via the organization or entity that originally conferred or issued an element used in credentialing or the data banks/s to which those organizations report (e.g., state licensing boards, schools/training programs, certifying boards, NTIS), NPDB, professional liability carriers, Office of Inspector General (OIG), Office of Personnel Management. Please find the Credentialing Data elements and how they are validated in the grid below:

Data Element/Requirement	Sources
Valid, current, unencumbered license for the state/s in which the applicant will provide care for Members	State Licensing Agency
Valid, current, unencumbered Drug Enforcement Administration or state narcotics registration (CDS)	National Technical Information Service (NTIS) Confirmation with the Drug Enforcement Agency (DEA) or Controlled Drug Substance (CDS) Agency Copy of the DEA or CDS Certification
Current active, in-force professional liability insurance	Provider's Application including Disclosure Questions and Release Copy of malpractice insurance face sheet
Work History	Provider Application Curriculum Vitae (CV)
Medicaid Sanctions	Office of Inspector General (OIG) Office of Personnel Management (OPM) National Practitioner Data Bank (NPDB)
Malpractice insurance claim history	National Practitioner Data Bank (NPDB) Self-reported explanation from practitioner
Board Certification	
<ul style="list-style-type: none"> • Physicians 	American Medical Association (AMA) American Board of Medical Specialties (ABMS) or its member boards Boardcertifieddocs.com American of Osteopathic Association (AOA) Physician Profile Report (web site)
<ul style="list-style-type: none"> • Podiatrists 	American Board of Podiatric Surgery (ABPS) American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
<ul style="list-style-type: none"> • Medical Dentist 	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards: <ul style="list-style-type: none"> - American Board of Endodontics - American Board of Oral & Maxillofacial Pathology - American Board of Oral & Maxillofacial Surgery - American Board of Orthodontics and Orthopedics

	<ul style="list-style-type: none"> - American Board of Pediatric Dentistry - American Board of Periodontics - American Board of Prosthodontics - American Board of Dental Public Health
<ul style="list-style-type: none"> • Advance Practice Nurse 	State Licensing Agency
	National Committee for Certifying Agencies:
	<ul style="list-style-type: none"> - American Nurse Credentialing Center (ANCC)
	<ul style="list-style-type: none"> - American Academy of Nurse Practitioner (AANP) - Pediatric Nursing Certification Board (PNCB)
<ul style="list-style-type: none"> • Neuropsychologists 	American Board of Clinical Neuropsychology
<ul style="list-style-type: none"> • Applied Behavior Analyst 	Behavioral Analyst Certification Board
Residency/Post-Graduate Training	American Medical Association (AMA)
	American of Osteopathic Association (AOA) Physician Profile Report (web site)
	Federation Credentials Verification Service (FCVS)
	State Licensing Board (for DPM's ONLY)
	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards
	Residency/Training Institution

Medical/Professional School	American Medical Association (AMA)
	American of Osteopathic Association (AOA) Physician Profile Report (web site)
	State Licensing Agency
	Medical/Dental/Chiropractic/Podiatrist School
	Degree Verify
	ECFMG certificate or number for international medical graduates licensed after 1986
	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards
Disciplinary history or adverse actions related to licensure/certification	National Practitioner Data Bank (NPDB)
	State Licensing Agency
	Chiropractic Information Network/Board Action Databank (CIN-BAD)
Hospital Privileges	Primary admitting hospital
	Provider's Application including Disclosure Questions and Release
Medical condition which may impair ability to practice medicine (reasons for any inability to perform the essential functions of the position, with or without accommodation)	Disclosure Questions
	Curriculum Vitae (CV)
	Self-reported explanation from practitioner

Community Based, Atypical, and Non-Traditional Providers

Aetna Better Health credentials non-medical community-based providers according to the requirements that best fit the standards of the profession in which they practice, or as required by the State. Providers in this category include home and vehicle modifications, transportation, and respite. Credentialing takes place at the time of initial contracting and re-credentialing occurs every three years.

The dedicated Medicaid Credentialing department performs Primary Source Verification via the organization or entity that originally conferred or issued licensing, and elements used in credentialing or the data banks/s to which those organizations report (e.g., state licensing or health department, schools/training programs, NTIS), NPPES, professional/general liability carriers, Office of Inspector General (OIG), System for Award Management. Please find the Credentialing Data elements and how they are validated in the grid below:

Data Element/Requirement	Sources
Valid, current, unencumbered business license for the state/s in which the applicant will provide care for members.	State Licensing Agency
Disclosure of Ownership	System for Award Management
	Provider's Application including Disclosure Questions and Release
	Copy of the Disclosure of Ownership form
Current active in force professional/general liability insurance	Provider's Application including Disclosure Questions and Release
	Copy of insurance face sheet
Medicaid Sanctions	Office of Inspector General (OIG)
	NPPES (National Plan & Provider Enumeration System)
	NPIDB (National Provider Identifier Database)

Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Discrimination Laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act of 1990 as amended
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)
- Affordable Care Act
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164
- Title IX of the Education Amendments of 1972
- Titles XIX and XXI of the Social Security Act

In addition, our providers must comply with all applicable laws, rules, and regulations, and as provided in applicable laws, rules, and regulations, our providers are prohibited from discriminating against any member on the basis of health status.

Financial Liability for Payment for Services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a provider may collect patient liability, client obligation or spenddown from members in accordance with the terms of the Member Handbook. Providers must agree to the following terms:

- Not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health; and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers authorized by Aetna to serve such members, as long as the member follows Aetna's rules for accessing services described in the approved Member Handbook
- Not to bill a member for medically necessary services covered under the plan, and to always notify members prior to rendering services of their potential financial responsibility
- Prior to furnishing a non-covered service, the member should sign a document notifying them that the service is not covered and that they agree to pay
- When referring a member to another provider for a non-covered service, providers must verify the member is aware of his or her obligation to pay in full for such non-covered services and must obtain a signed document from the member notifying them that the service is not covered and that they agree to pay

Recovery Notifications

How to Refund an Overpayment

If you identify that you have received an overpayment, please submit the following information within 60 calendar days of the identification:

- A check issued to Aetna in the amount of the overpayment
- The name and ID number of the member for whom we have overpaid (Include a copy of the member's Aetna ID card, if available)
- The dates of service
- Supporting documentation, including but not limited to:
 - A letter explaining the reason for the refund
 - A copy of your Remittance Advice
 - Any other documentation to assist in accurate crediting of the refund

Once Aetna receives the information, we will process the provider's identified claim overpayment. The completion and details of the applied refund will be included on the next Remittance Advice in the "Refund Amount."

Mail this information to the address(es) below:

If you are submitting a check,

Aetna Better Health of Kansas
Attention: Finance
PO Box 841004
Dallas, TX 75284-1004

If you are returning the original check issued by Aetna, please mail within 60 days to:

Aetna Better Health of Kansas
Attention: Finance

**4500 E. Cotton Center Blvd.
Phoenix, AZ 85040**

Overpayments Identified by Aetna

In the event Aetna identifies an overpayment we will notify the provider in writing. The recovery letter contains a detailed explanation of the request for reimbursement, the impacted claim(s), member's name, dates of services and provides a 60-calendar day timeframe for the provider to contest the recovery in writing to the health plan. In the event a provider agrees with the recovery letter and would like to submit a check to pay back the overpayment we ask the provider to follow the guidance presented in the recovery letter. If cause for overpayment is by fraud or misrepresentation, this process is not applicable.

If a provider has concerns about the recovery letter, the provider may contact Aetna in writing within 60 calendar days of the recovery letter date, to:

**Aetna Better Health of Kansas
Attention: Provider Experience
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210**

If Aetna Better Health does not receive a contest notice within the above timeframes, provider authorizes Aetna Better Health to recoup the requested reimbursement amount from current claims payments.

In Lieu of Services

Aetna Better Health understands that there are times when existing covered services do not completely meet the health needs of our members. When we come upon a member or group of members whose needs have not been met with current covered services, we will consult all available resources to find a solution for the member that will aim to improve quality of life and health outcomes. We determine rationale for the medical appropriateness of the service and request State approval before providing the proposed service. Should the services be approved, all in lieu of services require an authorization. We will always inform the member and their support system of all the options and will not require any member to receive in lieu of service instead of a covered service.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

[Back to Table of Contents](#)

Covered Services

The tables on the following pages show what services we cover. To receive reimbursement, all services must be medically necessary.

Benefits	Covered Service	Limitations
Allergy Testing	Covered	Procedure code 95165 is limited to 156 doses per year. Providers can request a prior authorization for services in excess of 156 doses. Medical necessity documentation must be submitted with the prior authorization request.
Audiology	Covered	Hearing aids are covered one every four years. Batteries are limited to 6 per month for monaural aids and 12 per month for binaural aids. Bone anchored hearing aid (BAHA) is limited to one every four years, with one replacement.
Chiropractor Services (Manual Manipulation of Spine)	Not Covered	
Cosmetic Surgery	Not Covered	
Court-Ordered Services	Covered	In coordination with state judicial system. Contact Medical Management for more information
Dental Services (Adult)	Partially Covered, Plus, Value Added Benefits	Contact SkyGen at 1-855-918-2256 or visit www.SKYGENusa.com
Dental Services (children)	Covered	Contact SkyGen at 1-855-918-2256 or visit www.SKYGENusa.com
Durable Medical Equipment (DME)/Assistive Technology Devices	Covered	Prior authorization required in some cases and some limitations apply

Emergency room Services	Covered	An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition to stabilize the patient.
Ambulance – Emergency Medical Transportation	Covered	Air transportation may require prior authorization
Vision Care (Child)	Covered	Contact SkyGen at 1-855-918-2258 or visit www.SKYGENusa.com
Vision Care (Adult)	One complete eye exam and one pair of glasses are covered, every year.	Contact SkyGen at 1-855-918-2258 or visit www.SKYGENusa.com
Hemodialysis	Covered	
Home Health Care	Covered	Prior authorization required
Hospice	Covered	
Infertility Testing and Services	Not Covered	
Hospital Services – Inpatient (acute care, maternity services, rehabilitation and special hospitals)	Covered	Prior authorization required
Laboratory and Pathology	Covered	Prior authorization may be required
Long Term Services and Supports (LTSS) Includes HCBS Services	Covered	Plans of Care (POC) or prior authorization may be required/
Nursing/Intermediate Care Facility Services (Includes Nursing Facility (NF), Nursing Facility/Mental Health (NF/MH), and ICF-IID)	Covered	Participating providers do not require prior authorization Prior authorization required for Non-Participating providers Members must have Nursing Facility or Swing Bed Level of Care (LOC)
Oncology Services	Covered	Prior authorization may be required
Transplant Services	Covered	Prior authorization required

Hospital Services – Outpatient	Covered	Prior authorization may be required
Surgical Services— Outpatient (Outpatient Surgery, Ambulatory Surgical Center)	Covered	Prior authorization may be required
Podiatry Services— (Children)	Covered	
Podiatry Services— (Adult)	See value added benefits below	
Pharmacy Services	Covered drug formulary	Prior Authorization may be required, for more information on prior authorizations or limitations, visit the link below: www.AetnaBetterHealth.com/Kansas/members/pharmacy
Physician Services— Physician services include preventative services, EPSDT, maternity services, family planning, and post-acute care. This list is not all-inclusive of all services. Standard age guidelines for these services Applies	Covered	EPSDT is limited to ages: <ul style="list-style-type: none"> • 0-20 for TXIX • 0-18 for TXXI
Prosthetics and Orthotics	Covered	Prior authorization may be required
Radiology Services (MRI, MRA, Nuclear Medicine, PET, X-Rays, and Pain Management)	Covered	Prior authorization may be required Contact Evicore at 1-888-693-3211 or visit www.evicore.com
Rehabilitative Therapy Services / (Habilitative, developmental and rehabilitative including OT/ST/PT)	Covered	Prior authorization may be required
Second medical/ surgical opinions	Covered	

Service coordination	Covered	
Skilled nursing care	Covered	Prior authorization required
Skilled nursing facility care (Long Term Care)	Covered	Participating providers do not require prior authorization Prior authorization required for Non-Participating providers
Sleep apnea studies	Covered	Prior authorization required for KAN Be Healthy (KBH) members Prior authorization required for bariatric surgical candidates
Smoking and Tobacco Cessation Counseling	Covered	
Non-Emergency Transportation — (medical appointments and pharmacy)	Covered	Contact Access2Care at 1-866-252-5634
Urgent Care Services	Covered	
Psychiatric Care-Inpatient	Covered	Prior authorization required Hospital must notify the plan
Substance Abuse Inpatient	Covered	Prior authorization required Hospital must notify the plan
Mental Health Outpatient	Covered	Some services require prior authorization
Substance Abuse Outpatient	Covered	Some services require prior authorization

Value-Added Benefits

In addition to the services listed above, value-added benefits are also available to members. Please note that there are no grievance and appeal rights for these benefits.

Members 21 yrs. and older receive \$500 per year for dental services. It can be used for things like dental exams/cleanings twice each year, annual bitewing X-rays, fillings and extractions, specific root canals (anterior and bicuspid/pre-molar), and topical fluoride treatments
The Healthy Rewards Incentive program is where members can get up to \$35 gift cards when they complete wellness activities such as: Vaccines, Yearly check-ups, Diabetic eye exams, HbA1C tests, Chlamydia screenings, cervical cancer screenings. (Below are the exact Healthy Rewards programs.)
<ul style="list-style-type: none"> • Healthy Rewards: Age 7 to Age 12 Exam: \$25 gift card for completing the exam.

<ul style="list-style-type: none"> • Healthy Rewards: Annual Check Up for Teens: \$35 gift card for completing the exam.
<ul style="list-style-type: none"> • Healthy Rewards: Annual Flu shot: \$25 gift card for successful vaccination.
<ul style="list-style-type: none"> • Healthy Rewards: Annual Mammogram: \$25 gift card for completion of exam.
<ul style="list-style-type: none"> • Healthy Rewards: Cervical Cancer Screening: \$25 gift card for completion of screening.
<ul style="list-style-type: none"> • Healthy Rewards: Chlamydia Screening: \$35 gift card for completion of screening.
<ul style="list-style-type: none"> • Healthy Rewards: Diabetic HbA1C Exam: \$25 gift card for completion of the first screening of the year.
<p>Free Android Smartphone with 350 free minutes per month, 1 gigabyte of data per month and unlimited text messaging for members 18 years and older.</p>
<p>Pregnant members are encouraged to make early and frequent prenatal and postnatal visits. The Promise Pregnancy Program includes a redeemable reward of \$75 for a first pre-natal visit within the first trimester or within 42 days of plan enrollment. Earn a \$75 gift card by completing a postpartum visit within 84 days of delivery. Earn a \$10 gift card for dental check-up during your pregnancy.</p>
<p>Free rides for members going to the pharmacy, WIC eligibility appointments and prenatal classes. Twelve (12) round trips per year for members going to job interviews, job training, shopping for work type clothing, food bank or grocery store for food, senior services and getting community health services otherwise not covered.</p>
<p>Provide membership to a 12-week class from the University of Kansas Weight Management program on healthy eating, exercise and behavior change.</p>
<p>Members age 5 to 18 can get up to \$50 per year for activities at participating YMCA, Boys and Girls Clubs, Boy Scouts or Girl Scouts.</p>
<p>Members who have diabetes, ages 21 and older will receive 2 podiatry visits each year.</p>
<p>Up to 120 hours of respite care per year for members on a waiver waiting list for Home and Community-Based Services. (This must be approved by the member's case manager).</p>

<p>Ted E. Bear, M.D.® Kids Club Program is for members from newborn to age 12. Member incentives include an Activity Book and up to \$25 gift cards (up to \$75 annually) for meeting identified goals.</p>
<p>For members 21 years and older with a medical need who have been discharged from an inpatient stay after 7 days in the hospital; up to 2 meals per day for up to 7 days.</p>
<p>Members age 0-18 with an asthma diagnosis and adult members with moderate to severe Asthma and currently on the following medications: Cinqair, Dupixent, Xolair, Fasenra, Nucala; will be offered an asthma purifier based on pharmacy utilization. The benefit is to help lower the chance of an asthmatic attack (one-time benefit).</p>
<p>With CampusEd, members age 16 and up, can get their GED and learn new job skills at no cost. Members who want to complete their GED will have access to specific prep courses, assistance in scheduling exam and a voucher to pay for the exam. In addition, members interested in expanding their job skills will have access to over 3000 resources in Health Care, IT, Business, and other trades. CampusEd provides career services support, resume assistance, opportunities to earn digital badges to show experience, and access to a local network of employers currently recruiting employees.</p>
<p>For members on an LTSS waiting list eligible for respite care we will provide one background check per year for a personal care services worker.</p>
<p>Up to 120 hours of respite care per year for members on a waiver waiting list for Home and Community -Based Services. (This must be approved by the member's case manager).</p>
<p>Members on the Intellectual/Developmental Disability(I/DD), Physical Disability (PD), Frail and Elderly (FE) or Brain Injury (BI), and waiver waiting list who own their own home, can get up to \$250 per calendar year towards pest control services.</p>
<p>Each household can order \$25 per month of certain Over-the-Counter (OTC) drugs and supplies from a catalog. Monthly supplies can be ordered online or by phone. The items will be mailed directly to the member's home.</p>
<p>Members on the FE, PD, BI and I/DD waivers can receive up to 16 hours of hospital companionship per year provided by their personal care service worker while the member is in the hospital.</p>
<p>No Place Like Home is a grant program that supports community-based organizations assisting members to access or maintain housing. Funds provide one-time emergency housing assistance to help keep members in their home or to establish a new home in the community.</p>
<p>Through Pyx Health, members can download an application that helps them fight loneliness. Members can connect with compassionate humans for a friendly chat or help with resources.</p>
<p>Access to MyActiveHealth for self-management health tools, personal health records, health assessments and lifestyle coaching</p>
<p>Members on the Intellectual/Developmental Disability(I/DD), Physical Disability (PD), Frail and Elderly (FE) or Brain Injury (BI), Technology Assisted (TA) and waiver waiting list who own their own home,</p>

can get up to \$250 per calendar year towards pest control services.

Healthy food gift card for members with diabetes or congestive heart failure. Members can receive \$30 a month for three months on a reloadable gift card restricted to healthy food. The member must be involved with a Care Manager who will provide them with the gift card in order for them to buy healthy food at their local grocery store. The Care Manager can assist them with signing up for SNAP benefits.

Through iFoster we will provide a tablet to youth ages 13 to 17 along with digital literacy training and access to a large number of supportive online resources for supporting existing youths in foster care.

Foster youth in transition from one location to another will receive a duffle bag filled with personal hygiene items, supplies and a blanket to assist with their transition another location. This is a one-time per calendar year benefit.

In the event of a benefit change, we will notify providers 30 days prior to the changes.

Telemedicine

Telemedicine services are available to members and may be provided as medically necessary. Telemedicine is the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. These services include Telehealth and Remote Patient Monitoring. Telemedicine services expand both the access and the reach of network providers, while increasing access for members in rural and underserved areas as well. Telemedicine services are provided with an aim to increase service coordination and continuity and address gaps in care with innovative technologies.

Telehealth is the delivery of physical or behavioral health care services or consultations with a real-time two-way audio-visual platform. Providing telehealth services to our members can break down access barriers and help our members receive high quality care where and when they need it. Telehealth also provides an easy-to-use option for providers to deliver, and members to receive care. Member can be referred or can self-refer and be connected to licensed professionals, receiving answers to general health questions or medical services. Practitioners who have been identified through outreach or who have expressed in interest in participating in telehealth services provision are given access to the web-based platform. They receive education on the use of the telehealth platform and how to conduct virtual e-visits with their patients.

Remote patient monitoring is the remote monitoring of a member's vital signs, biometrics, or other subjective data through a device that transmits this information to a clinician for analysis, storage, and when indicated, intervention. Through the Remote Patient Monitoring program, members with chronic or high-risk conditions Failure such as congestive heart failure, diabetes, asthma and high-risk pregnancy will receive member-centric in-home health management support focused on early intervention, self-management and adherence to a prescribed plan of care. Members enrolled in the Remote Patient Monitoring program receive a kit with plug-and-play, Wi-Fi enabled devices that measure, and record results obtained by the member during a daily health session. The results can include vital signs and biometrics such as blood pressure, weight, or blood sugar, as well as subjective

data such as responses to surveys or presentation of educational material. Participation is voluntary, and members can be referred to the program by their health plan care manager, their Primary Care Provider, a network Specialist or even self-refer. Practitioners are actively included in the program and given access to the monitoring tools to follow the progress of their patients. In addition, network providers have access to detailed information and materials to introduce their patients to the Remote Patient Monitoring program.

Spenddown

The Medically Needy program offers coverage to people who have income over the maximum allowable income standard. The spenddown amount is the member's share of their family's medical bills. The spenddown amount is like an insurance deductible. If the member has a spenddown amount, they are responsible for that amount and we would only pay any medical bills over that amount.

A spenddown can be set for members who fall into one or more of the following groups:

- Pregnant women
- Children under the age of 19
- Seniors age 65 and over
- Persons determined disabled by Social Security

The members' spenddown amount is different for every family. The eligibility worker determines the amount of the spenddown amount and sends a letter to the member outlining the amount. A medical card is sent for each person in the member's family who lives with them and is on their spenddown program. Members are informed that the medical card will not pay any bills until the spenddown amount is met. Members on a spenddown will give the medical card to their provider while in the "unmet" status for the provider to bill. Although the provider bills, the amount is not paid. However, that amount is deducted from the members overall spenddown amount. If the member has any questions, please ask that they call Member Services at **1-855-221-5656**.

Long Term Services and Supports (LTSS)

Some of our members are eligible for LTSS. To qualify for LTSS, a member must meet the state's criteria for needing an institutional level of care, as well as meet certain financial requirements. A member does not need to reside in a nursing facility or some other institutional facility to get LTSS. A member can get these services in their home or assisted living facility.

Home and Community Based Waivers (HCBS)

The following is a summary of the Home and Community Based Services waiver programs that are offered if a member wants to get services in their home or assisted living facility:

- **Frail Elderly:** The Frail Elderly (FE) waiver provides individuals age 65 and older an alternative to nursing home care. The program promotes independence within the community and helps to offer residency in the most integrated environment.
- **Physical Disability:** The Physical Disability (PD) waiver serves individuals 16 to 64 years of age an alternative to nursing home care. The program promotes independence within the community and helps to offer residency in the most

integrated environment.

- **Intellectual and Developmental Disability:** The Intellectual / Developmental Disability (I/DD) waiver serves individuals age five and older who meet the definition of intellectual disability, having a developmental disability or are eligible for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation three or more areas of life functioning.
- **Serious Emotional Disturbance:** The Serious Emotional Disturbance (SED) waiver provides children, with some mental health conditions, special intensive support to help them remain in their homes and communities. Parents and children are actively involved in planning for all services.
- **Autism:** The Autism (AU) waiver provides support and training to parents of children with an Autism Spectrum Disorder (ASD) diagnosis to help ensure children with ASD can remain in their family home. This waiver can serve children from time of diagnosis through 5 years of age.
- **Technology Assisted:** The Technology Assisted (TA) waiver provides services to individual's ages 0 through 21 years old who are chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function. Eligible individuals require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting to avert death or further disability.
- **Brain Injury:** The Brain Injury (BI) waiver program serves individuals 0 to 64 years of age who would otherwise require institutionalization in a BI rehabilitation facility. The BI program is not considered a long-term care program and is designed to be a rehabilitative program for participants to receive therapies and services that enable them to rely less on supports as the participant's independence increases.

Waiver Services

If you qualify for waiver benefits you may be eligible for these services:

Autism	Brain Injury	Frail Elderly	Intellectual/Developmentally Disabled
<ul style="list-style-type: none"> • Family Adjustment Counseling • Parent Support and Training • Respite Care • Financial Management Services 	<ul style="list-style-type: none"> • Cognitive Therapy • Physical Therapy • Occupational Therapy • Speech-Language Therapy • Behavior Therapy • Transitional Living Skills • Personal Care Services • Personal Emergency Response System • Home-Delivered Meals • Medication Reminder • Medication Dispenser • Enhanced Care Support • Financial Management Services • Assistive Services 	<ul style="list-style-type: none"> • Adult Day Care • Attendant Care • Comprehensive Support Services • Financial Management Services • Home Telehealth • Medication Reminder • Nurse Evaluation Visit • Personal Emergency Response System • Enhanced Care Support • Wellness Monitoring • Assistive Services 	<ul style="list-style-type: none"> • Overnight Respite • Supported Employment • Personal Care Services • Medical Alert Rental • Wellness Monitoring • Specialized Medical Care (RN/LPN) • Enhanced Care Support • Targeted Case Management • Financial Management Services • Residential Supports • Day Supports • Assistive Services

Physical Disability	Serious Emotional Disturbance	Technology Assisted
<ul style="list-style-type: none"> • Personal Care Services • Personal Emergency Response System • Home Delivered Meals • Medication Reminder • Medication Dispenser • Enhanced Care Support • Financial Management Services • Assistive Services 	<ul style="list-style-type: none"> • Attendant Care • Independent Living/Skills Building • Parent Support and Training • Professional Resource Family Care • Short Term Respite Care • Wraparound Facilitation 	<ul style="list-style-type: none"> • Specialized Medical Care • Health Maintenance Monitoring • Intermittent Intensive Medical Care • Personal Care Services • Medical Respite Care • Financial Management Services • Assistive Services

LTSS service coordination

Members who are eligible for LTSS are assigned a service coordinator. Members will receive service coordination services for as long as they stay with the LTSS program. The member's service coordinator will work with you (the provider), the member, their representative or guardian (if applicable), to help decide which services will best meet the member's needs.

Service Plan

Aetna Better Health follows the KDADS policy specific to the development, monitoring and evaluation of the Service Plan, and have internal audits to ensure compliance with rules and regulations.

Policy

Autism, Frail Elderly, Physical Disability, Technology Assisted and Brain Injury Person-Centered Service Plan <https://kdads.ks.gov/kdads-commissions/long-term-services-supports/hcbs-policies>

Credentialing

Aetna Better Health credentials and re-credentials HCBS providers consistent with applicable waiver provider qualification requirements and credentialing standards identified by the State for HCBS providers and verify HCBS provider compliance with Federal settings requirements. We make certain that 1915(c) provider qualifications are met both initially and ongoing through the credentialing and re-credentialing process.

In addition, Aetna Better Health follows the KDADS policy specific to Provider Qualifications, Certification and Credentialing Commission - All HCBS Waivers which includes oversight of monitoring information:

https://kdads.ks.gov/docs/librariesprovider17/ltss/hcbs/hcbs-policies/general/m2017-171-hcbs-provider-qualification-policy.pdf?sfvrsn=38d2920e_3

Additional Resources

- Kansas Department for Aging and Disability Service (KDADS) – Policies: <https://www.kdads.ks.gov/provider-home/archived-final-policies>
- Commission Website: [https://www.kdads.ks.gov/commissions/home-community-based-services-\(hcbs\)](https://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs))
- Kansas Medical Assistance Program (KMAP) manuals: <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderPublications>

Medical Necessity

Medically necessary services are accepted services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.

This definition is based on Kansas Administrative Regulations (K.A.R.) 30-5-58, the Centers for Medicare & Medicaid Services (CMS), and American College of Medical Quality (ACMQ) definitions. Such services include:

- Provided for the diagnosis or direct care and treatment of the medical condition
- To achieve age-appropriate growth and development
- To attain, maintain, or regain functional capacity
- Meet national clinical standards and the standards of good medical practice within the medical community in the service area
- Not primarily for the convenience of the plan member, caregiver, or a plan provider
- The most appropriate level or supply of service which can safely be provided

You can view a current list of the services requiring authorization on our website at www.AetnaBetterHealth.com/Kansas

If you have questions or would like to get training on the Prior Authorization Requirement Search Tool, please contact our Provider Experience department at **1-855-221-5656**.

Affirmative Statement Regarding Incentives

Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other employees/individuals for issuing denial of coverage. Financial incentives for utilization making decision makers do not encourage decisions that result in underutilization. Aetna's affirmative statement declares that our organization does not use incentives or disincentives to encourage barriers to care and service.

Emergency Services

Aetna Better Health covers emergency services without requiring prior authorization for members, whether a contracted or non-contracted provider provides the emergency services. Aetna Better Health will not limit what constitutes an emergency medical condition based on diagnoses or symptoms.

Aetna Better Health recognizes treatment for an Emergency Medical Condition emergency medical condition or cases in which prudent layperson, who possesses an average knowledge of health and medicine, reasonably thought that the absence of immediate medical attention would result in at least one of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part; when the absence of immediate medical attention would not have resulted in placing the individual in serious jeopardy, pursuant to 42 C.F.R. § 438.114

Aetna Better Health abides by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Emergency Transportation

If a member has an emergency and has no way to get to a hospital, please have them call 911. The plan covers ambulance rides on the ground in a medical emergency for all members.

Non-Emergent Transportation

Aetna Better Health members can receive non-emergent transportation services through Access2Care. Transportation appointments must be scheduled three (3) days in advance. To find out how a member can get a ride to his/her doctor appointment, please reference the contact information below:

Members can schedule a ride through (reservations): **1-866-252-5634 (TTY: 711)**.

The member should have the following information when calling to schedule transportation:

- Name of the doctor
- Address
- Telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)

If the member has an urgent need for transportation, have them contact Member Services to request assistance with the urgent request.

Laboratory Services – Lab Corp

Lab Corp provides laboratory services. If a member has questions about laboratory services, please have them visit Lab Corp website's at: www.labcorp.com/

If a member and or provider have questions about lab services, please call Lab Corp at **1-888-522-2677**.

Pharmacy Services

You can find a more comprehensive description of covered services in Chapter 15.

Vision Services – SKYGEN

SKYGEN provides vision services. SKYGEN covers the following services for members:

- For members under age 21, exams, eyeglasses and repairs as needed
- For members over age 21, exams and one pair of glasses per year, along with \$50 to use for non-covered vision services.

If a member has questions about vision services, please have them call SKYGEN at **1-855-918-2259**. If a provider has questions, please call **1-855-918-2258**.

Website: www.SKYGENusa.com

Dental Services – SKYGEN

Dental services are provided through SKYGEN. If a member has questions about dental services, please have them call SKYGEN at **1-855-918-2257**. If a provider has questions, please call **1-855-918-2256**.

Website: www.SKYGENusa.com

Interpretation Services

Telephonic interpretive services are available 24 hours per day, 7 days per week at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health's Member Services department at **1-855-221-5656**.

CHAPTER 6: BEHAVIORAL HEALTH

[Back to
Table of
Contents](#)

Mental Health/Substance Use Disorder Services

We define behavioral health as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include abuse of alcohol and other drugs. To meet the behavioral health needs of our members, Aetna Better Health provides a continuum of services to members at risk of or experiencing symptoms of mental, addictive, or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with behavioral health providers experienced in providing behavioral health services to our population.

We work collaboratively with health care providers, including Community Mental Health Centers (CMHCs) / Certified Community Behavioral Health Clinics (CCBHCs), and Community Developmental Disability Organization (CDDOs), as well as a variety of community agencies and resources to successfully meet the needs of members with mental health and substance use disorders, including those participating in waiver programs (e.g., SED, autism) and those with Intellectual/Developmental Disabilities (I/DD).

In addition, for all categories of members, we cover the diagnosis of diseases of organic origin categorized as altering the mental status of a member.

Assessments

Aetna Better Health will conduct an assessment for members with LTSS and behavioral health needs within 14 days of enrollment.

Availability

Mental Health/Substance Use Disorder (MH/SUD) providers must be accessible to members, including telephone access, in order to advise members requiring urgent or emergency services. If the MH/SUD provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. We require MH/SUD providers to meet our contractual standards for urgent and routine behavioral health appointments. For a complete list, please see Chapter 5 of this Manual.

Referral Process for Members Needing Mental Health/Substance Use Disorder Assistance

Members can self-refer to any participating MH/SUD provider with our network without a referral from their Primary Care Provider (PCP).

PCP Role in Behavioral Health Services

We promote early intervention and health screening for identification of behavioral health concerns and patient education. We expect providers to:

- Screen, evaluate, treat, and refer (as medically appropriate) any behavioral health problem/disorder
- Treat mental health and substance use disorders within the scope of their practice
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to an Aetna Better Health behavioral health care provider without a referral from the member's PCP

Coordination between Behavioral Health and Physical Health Services

We are committed to coordinating medical and behavioral health care for members who are appropriately screened, evaluated, treated, and referred for physical health, behavioral health, or substance use disorder, dual, or multiple diagnoses, or developmental disabilities. With the member's permission, our service coordination staff can facilitate coordination of services related to substance use screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. We encourage PCPs to use behavioral health screening tools, treat behavioral health issues within their scope of practice, and refer members to behavioral health providers when appropriate. Provider screen members seen by behavioral health providers for co-existing medical issues. Behavioral health providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. We ask MH/SUD providers to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

We share information with participating behavioral health and medical providers to verify interactions with the member result in appropriate coordination between medical and behavioral health care.

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES

[Back to
Table of
Contents](#)

Aetna Better Health of Kansas is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. You must comply with member rights and responsibilities, especially treating members with respect and dignity. Understanding member rights and responsibilities is important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is our policy not to discriminate against members based on race, color, national origin, age, disability or sex, except where medically indicated, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

If we are made aware of an issue with a member not receiving the rights as identified below, we will initiate an investigation and report the findings to the Quality Management Committee and further action may be taken.

Member Rights

Members are free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers or the State agency treat the enrollee.

Members, their families, and guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member's condition and ability to understand. This includes, but is not limited to:

- A right to receive information about your organization, its services, its practitioners and providers, and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- A right to receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- A right to voice complaints or file grievances and appeals about us, our practitioners and providers, or the care your organization provides. This includes the right to information about how to submit a complaint, grievance, appeal, or request for hearing.
- A right to make recommendations regarding your organization's member rights and

responsibilities policy.

In addition, members have the following rights:

- Information requirements. Each member will receive information in accordance with 42 CFR § 438.10.
- Copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended.
- A right to information regarding applicable copays or other costs for which the member is responsible.
- A right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to treatment that is nondiscriminatory based on race, color, national origin, age, disability or sex.
- A right to receive information and treatment considerate of members' cultural or ethnic backgrounds that considers members' language limitations/reading needs and limitations, and visual or auditory limitations.
- A right to free interpreter services for members with limited English proficiency or with hearing impairments.
- A right to receive information about advance directives and to execute or nullify advance directives.
- A right (of the member or member's authorized representative) to access member records in accordance with applicable federal and state law, including Health Insurance Portability and Accountability Act (HIPAA).
- A right for members or members' authorized representatives to request amendments and corrections to the member's medical record in accordance with law.
- A right to choose a primary care provider from our network.
- A right to a second opinion from an appropriately qualified participating health care professional at no cost to the member. If network provider is not available, we will arrange for a second opinion out-of-network at no more cost to the member than if the service was obtained in-network.
- A right to obtain emergency care without prior approval from us or the member's PCP regardless of whether the emergency care facility is in network.

Member Responsibilities

Aetna Better Health of Kansas members, their families, or guardians have the responsibility to:

- Supply information (to the extent possible) that we and our practitioners and providers need to provide care.
- Follow plans and instructions for care that have been agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Read the Member Handbook and other plan documents that convey information pertinent to utilizing services and working with us.
- Follow our rules explained in the Member Handbook and other plan documents.

- Know the name of their assigned PCP and Service Coordinator.
- Show their identification (ID) card to each provider and pharmacy before obtaining services.
- Protect their member ID card and to report lost or stolen ID card to us.
- Use the emergency room (ER) for true emergencies only.
- Schedule and keep appointments with providers and practitioners, allowing for 24-hour notice when the appointment must be changed or canceled.
- Treat the providers, practitioners, and other staff with respect.
- Inform us and the Clearinghouse when the member's address or phone number changes.
- Report family changes that might affect eligibility or enrollment to the Clearinghouse including changes in family size, employment, and moving out of state.
- Report other health insurance coverage, including Medicare, to us and the Clearinghouse.
- Provide the treating practitioner with a copy of the member's living will and advance directive as applicable.

Member Rights under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits, and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People with a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of disability, do the following:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits, or opportunities to participate as a result of physical barriers

CHAPTER 8: ELIGIBILITY AND ENROLLMENT

[Back to
Table of
Contents](#)

To become a member with Aetna Better Health of Kansas, a member must first be eligible for KanCare. Eligibility is determined by KDHE in conjunction with CMS. Benefits are predetermined by KDHE and not us. KDHE must approve a member's eligibility for KanCare and their enrollment with us.

Our Members

Our members may include individuals that fall into one or more of the following categories:

- All Medicaid and all CHIP recipients
- Adults and children eligible under the Caretaker Medical program
- Certain newborn children through the month of their first (1st) birthday
- Children up to the age of 19
- Aged and disabled individuals receiving Supplemental Security Income (SSI)
- Medically needy aged and disabled individuals (spenddown populations)
- Employed persons with disabilities receiving coverage under the Medicaid Buy-in (Working Healthy)
- Children in foster care
- Children whose families receive adoption support
- Beneficiaries receiving long-term care – including institutional care, HCBS, and Money Follows the Person

Open Enrollment

Members have the option to change health plans during the initial 90 days after the effective date of enrollment. Thereafter, members can change health plans annually during open enrollment.

ID Card

Members should present their Aetna Better Health of Kansas ID card at the time of service. The Aetna Better Health of Kansas ID card notes whether the member has a copay. Currently, our members do not have copays.

The member ID card contains the following information:

- Member name
- Member ID number
- Date of birth of member
- Member's gender
- PCP name
- PCP phone number
- Effective date of eligibility
- Claims address
- Emergency contact information for member

- Health plan name - Aetna Better Health
- Aetna Better Health logo
- Aetna Better Health's website address
- Carrier Group Number
- RX Bin Number
- RX PCN Number
- RX Group Number
- CVS Caremark Number (For Pharmacists use only)

Sample ID Card

Aetna Better Health® of Kansas
Medicaid



Name LastName, FirstName

Member ID # 0000000000

DOB 00/00/0000 Sex X

PCP LastName, FirstName

PCP Phone 000-000-0000

Effective Date 00/00/0000

RxBIN: 610591

RxPCN: ADV

RxGRP: RX8849

Pharmacist Use Only: 1-844-234-8268



THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

MEKS

Verifying Member Eligibility

Presentation of an Aetna Better Health of Kansas ID card is not a guarantee of eligibility or reimbursement. The provider is responsible for verifying a member's current enrollment status before providing care. We will not reimburse for services provided to members not enrolled with us. Providers can obtain the most up-to-date eligibility information at KMAP. Providers can also verify member eligibility online through the Availity Web Portal at <https://apps.availity.com/availity/web/public.elegant.login> or by calling the Member Services department at **1-855-221-5656**.

CHAPTER 9: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

[Back to Table of Contents](#)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. The EPSDT Program was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

The EPSDT Program consists of two mutually supportive, operational components:

- 1. Assuring the availability and accessibility of required health care resources**
- 2. Helping members and their guardians effectively use these resources**

These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations and to diagnose and treat early any health problems found, before they become more complex and their treatment costlier.

KAN Be Healthy (KBH) – EPSDT Specific Requirements

Kansas has adopted the Bright Futures/AAP Periodicity Schedule as a standard for pediatric preventive services through EPSDT programs. The KAN Be Healthy (KBH) program follows the American Academy of Pediatrics Periodicity Schedule on the Bright Futures website. For more information about KAN BE Healthy, refer to the Kan Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment manual located at:

https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/KBH_22161_20238.pdf

Periodicity Schedule

The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at:

https://brightfutures.aap.org/clinical_practice.html

EPSDT Services

EPSDT services include:

- A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all medically necessary

diagnostic and treatment services to correct or ameliorate a physical or mental condition identified during a screening visit.

- A comprehensive unclothed physical examination including vision and hearing screening; dental inspection; and nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by ACIP for pediatric vaccines. Providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits and necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.
- Appropriate laboratory tests i.e.:
 - Hemoglobin/Hematocrit/EP
 - Urinalysis
 - Tuberculin Test – intradermal, administered annually and when medically indicated
 - Lead screening using blood lead level determinations must be done for every Medicaid-eligible person:
 - Between 9 months and 18 months, preferably at 12 months of age
 - At 18-26 months, preferably at 24 months of age
 - Any child not previously tested
 - Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and obtained as necessary.
- Health education/anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate)
- EPSDT screening services reflect the age of the child and are provided periodically according to the following schedule:
 - Neonatal exam
 - 3 – 5 days after birth
 - 1 month
 - 2 months
 - 4 months
 - 6 months
 - 9 months
 - 12 months
 - 15 months
 - 18 months
 - 24 months
 - 30 months
 - Annually through age 20 years

Identifying Barriers to Care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50% of children in the study sample received any documented EPSDT services. To address this, we instruct our member services and Service Coordination staff to identify potential barriers to care during communications with members, their family/caregivers, PCPs, and other relevant entities and work to help members maintain access to services.

Examples of barriers to preventive care we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. We also notify members annually of their eligibility for EPSDT services and encourage the use of the services.

Educating Members about EPSDT Services

Aetna Better Health informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that we offer, through the following mechanisms:

- Member Handbook & Evidence of Coverage
- Member newsletters and bulletins
- Aetna Better Health's website
- Educational flyers
- Reminder postcards
- Care plan interventions for high-risk members enrolled in service coordination

Provider Responsibilities in Providing EPSDT Services

Participating providers are contractually required to provide EPSDT screenings and immunizations to children age birth to 21 years of age in accordance with Bright Futures/AAP periodicity schedule, including federal and state laws standards and national

guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and as federally mandated). Details of required services are found under “EPSDT Services” shown above. Additionally, participating providers are contractually required to:

- Comply with our Minimum Medical Record Standards for Quality Management, EPSDT Guidelines, and other requirements under the law
- Cooperate with our periodic reviews of EPSDT services, which includes chart reviews to assess compliance with standards
- Report members’ EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form
- Document in medical record and follow-up on missed or cancelled appointments, including contacting members or their parents/guardians after a missed EPSDT appointment to reschedule
- Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment, and date information is received verifying the appointment occurred.

We require providers to make the following recommended and covered services available to EPSDT-eligible children, at the ages recommended on the state Medicaid regulator’s periodicity schedule:

- Immunizations, education, and screening services provided at recommended ages in the child’s development, including the following:
 - Comprehensive health and developmental history (including assessment of both physical and mental health development).
 - Comprehensive unclothed physical exam.
 - Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
 - Laboratory tests.
 - Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. The physical or dental exams provide the initial context for providing health education. Health education and counseling to both parents (and guardians) and children is required. This is 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, as well as accident and disease prevention.
 - Vision services, including periodic screening, treatment for defects in vision, including eyeglasses.
 - Dental services, including oral screening, periodic direct referrals for dental examinations according to the state periodicity schedule, relief of pain and infections, restoration of teeth, and maintenance of dental health.
 - Hearing services, including, at a minimum diagnosis and treatment for defects in hearing, including hearing aids.
 - Lead toxicity screening consists of two components: verbal risk assessment and blood lead testing in accordance with CMS and KAN Be Healthy state requirements.

- Diagnostic services, including referrals for further evaluation as indicated through a screening examination.
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services.

Provider Monitoring

The methods we utilize to monitor our providers' and members' compliance/success in obtaining the appropriate care associated with Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

1. Analysis and evaluation of provider utilization
EPSDT Audit and other provider office visits
EPSDT Compliance Report
2. Tracking and trending provider data
3. Evaluation of performance measures and outcome data including Healthcare Effectiveness Data, Information Set (HEDIS[®]) and EPSDT results (monitoring results on a monthly basis)
4. Review and tracking of member complaints, grievances, and appeals and provider complaints to identify trends
Peer review of quality, safety, utilization, and risk management referrals
Credentialing review activities
Review of gaps in care reports and analysis of data from PCP profiles and performance reports
Review of sentinel events
5. Monitoring network capacity and availability and accessibility to care delivery systems

Our Provider Experience Team educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Experience staff may take referrals from a provider to have a member outreached by service coordination staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services staff may also take referrals from providers who identify problems through EPSDT exams.

PCP Notification

Aetna Better Health provides all PCPs with a list of members who have not had a visit or who have not complied with the EPSDT periodicity and immunization schedules for children.

Direct-Access Immunizations

Members may receive influenza and pneumococcal vaccines from any provider without a referral at no cost to the member if it is the only service provided at that visit.

Vision Services

At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. The vision screening of an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment for each child beginning at three years of age.

Dental Services

Dental services are not limited to emergency services. Dental exams in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after one year of age or soon after the eruption of the first primary tooth is mandatory. Thereafter there must be, at a minimum, a dental visit twice a year with confirmation by the PCP during well child visits to verify that all needed dental preventative and treatment services are provided through the age of 20 years.

Mental Health/Substance Use Disorder

When there is an indication of possible MH/SUD issues, a MH/SUD-screening tool is used to evaluate the member and pertinent findings are documented. Based on findings of the screening(s), necessary mental health and substance use referrals are made and services/treatments are provided.

If you experience service and or KAN Be Healthy EPSDT related issues, please send an e mail to our EPSDT Coordinator at: **ProviderExperience_KS@AETNA.com**.

Members with Special Needs

Adults with special needs include our members with complex or chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are enrolled in HCBS waiver and WORK programs, are homeless, or are living in institutional settings.

Children with special needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition, youth in foster care, and those who require health and related services of a type or amount beyond that generally required by children. Additionally, children with special needs may be identified because they are enrolled in HCBS waiver programs, are homeless, or are living in institutional settings.

We developed methods for:

- Promoting well-child care to children with special needs who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of members
- Coordination and approval of home therapies and home care services when indicated
- Service coordination for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so long-term complications may be treated as necessary
- Service coordination systems to confirm that children with serious, chronic, and rare disorders receive appropriate and timely diagnostic work ups
- Access to specialty centers inside and outside of our network for diagnosis and treatment of rare disorders

The initial Health Screening for new members assists us in identifying those with special needs. We also review hospital and pharmacy utilization data. Additionally, we rely on you, our providers, to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we follow up with a health risk assessment and comprehensive needs assessments (including condition specific assessments).

Aetna Better Health has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member, however services will require prior-authorization for out-of-network providers.

Aetna Better Health develops service plans that address the member's service requirements with respect to specialist physician care, durable medical equipment (DME), medical supplies, home health services, social services, transportation, etc. Our service coordination and utilization management teams collaborate closely so all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out-of-network.

We work to provide immediate transition planning for a new member with complex or chronic conditions or any special needs. The transition plan includes the following:

- Review of existing service plans
- Preparation of a transition plan to maintain continual care during transfer to the plan
- Coordination and follow-through to approve and provide any necessary DME, if it was ordered prior to the member's enrollment with us and was not received by the date of enrollment with us

Outreach and enrollment staff are trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and they use our Relay system and American Sign Language interpreters, if necessary.

If upon enrollment or diagnosis a member requires very complex, highly specialized health care services, the member may receive care from a contracted specialist, or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center is responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, can treat the member without a referral from the member's PCP, and may authorize such referrals, procedures, tests, and other medical services. If approval is obtained to receive services from an out-of-network provider, the care is provided at no additional cost to the member. If our network does not have a specialist or specialty care center with the expertise the member requires, we authorize out-of-network care.

We arrange for the provision of dental services to members with developmental disabilities. At a minimum, dental services coverage provides:

- Consultations and assistance to the member's caregivers
- Adequate time for members with developmental disabilities, knowing that initial and follow-up comprehensive dental visits may require up to 60 minutes on average. Our standards allow for up to four visits annually without prior authorization.
- Home visits when medically necessary and where available
- Adequate support staff to meet the needs of the members

- Use and replacement of fixed, as well as removable, dental prosthetic devices as medically necessary and appropriate
- Reimbursement for preoperative and postoperative evaluations associated with dental surgery
- A dental management plan
- Processing of authorizations for dental required hospitalizations by consulting with our dental and medical consultants in an efficient and time-sensitive manner

After-hours protocol for members with special needs is addressed during initial provider trainings and in this Provider Manual. Providers must be aware that non-urgent conditions for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Nurse Line is available 24 hours per day 7 days per week for members with an urgent or crisis situation.

We require our providers to confirm the use of the most current diagnosis and treatment protocols and standards established by the State of Kansas and medical community. During initial provider orientations, we highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

Model of Care

Our person-centered model of care integrates behavioral health, physical health, and social determinants of health to promote and support independence for the entire population we serve. Our model of care offers an integrated service coordination approach, with enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, and service coordination result in a comprehensive and integrated service plan for members. We utilize evidence-based practices for all members including those with special needs, such as children in foster care, children with intensive behavioral health needs, adults with behavioral health needs, individuals in an institutional setting, and individuals enrolled in HCBS waiver and WORK and other employment programs. We collaborate with child welfare agencies, agencies serving individuals with I/DD, criminal and juvenile justice systems, community service organizations such as Area Agencies of Aging (AAAs), targeted case management agencies, and educational systems to meet the needs of our members.

With our members at the center of all we do, our service coordination roles and responsibilities include the following, among others:

- Completion of health screening, health risk assessment, and needs and condition-specific assessments
- Development, implementation, monitoring, and approval of a plan of service
- Choice counseling
- Trauma-informed care
- Physical health coordination
- Behavioral health coordination
- Transportation coordination
- Member contacts and home visits
- Linkage and referral to community resources and non-Medicaid supports
- Health and safety monitoring
- Education, employment, and housing support, including referrals, advocacy, and follow-up
- Coordination with case managers from child-placing agencies, CDDOs, ADRCs, CMHCs, etc.
- Chronic condition management
- Screening for depression, substance use, and other conditions impacting quality of life and wellness
- Transition of care support
- Options counseling and service coordination for independent living in the community from institutional care
- Referrals for home and community-based services
- Referrals for education, housing, and employment supports
- Provider engagement, outreach

- Facilitation of continuity of care
- Monitoring PCSPs

Our inclusive and integrated system of care includes a coordinated network of physical, behavioral health, and LTSS providers, including I/DD providers. Our program's combined provider and service coordination activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Promote the provision of the right care in the least restrictive setting
- Support recovery and resiliency
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across health care settings and providers
- Promote appropriate utilization of services and cost-effective service delivery
- Employment support services specialists to help members with employment, including resume writing, interview coaching, and links to jobs
- Caregiver support, peer groups, and workshops
- Health and life coaching
- Housing specialists to link members to resources for accessible housing, utility assistance, and resources for home modifications

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

- Review network adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated service coordination program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.
- Promote strategies and interventions to support member independence and living in the least restrictive environment whenever possible, which includes:
 - Safe housing needs
 - Services and supports to assist the member in the least-restrictive community setting
 - Comprehensive care including meeting the needs of the member's chronic conditions, and their functional and behavioral health needs
 - Medication management including mail order options
 - PCP visits post-transition as medically indicated
 - Clinical preventive services including adult screenings
 - Non-Medicaid-covered community services to improve health and quality of life
 - Supported employment or volunteer work for members who choose this experience
 - A dedicated transition coordinator who works closely with our UM and Service Coordination staff to initiate transition planning activities and to evaluate the member's ability to transition to an alternative setting

- Interdisciplinary pod model that is connected to the array of resources necessary to help ensure members safely transition to alternative settings with sustainable success
- Population health specialist to advance the capabilities and knowledge of our provider network by helping providers move along the continuum of value-based payment models
- Project ECHO, which connects licensed professionals for episodic (acute) services and general health questions and where members can talk with a telehealth provider
- Support of provider partners to expand our capacity and expertise, such as increasing availability of alternative levels of care (e.g., medication-assisted treatment and intensive outpatient services for substance use)
- Data-driven solutions, such as CareUnify, to help drive focused relationships with members, providers, and other stakeholders through real-time, actionable information

Our Service Coordinators are responsible for identifying the member-centered cross-functional team. The cross-functional multidisciplinary team includes the member and circle of support, external stakeholders, community service organizations, advocacy organizations, and providers as appropriate to support initial service plan development for members with complex conditions, transitions of care, etc. Many components of our integrated service coordination program influence member health. These include:

- Bi-directional communication approaches, such as providing BH health education to physical health providers and vice versa.
- Data sharing solutions such as CareUnify offers providers information necessary for optimal treatment.
- Providing a primary care and pediatric toolbox, which is available to primary care providers by means of our provider portal: The toolbox provides recommendations for the treatment of conditions such as depression, attention-deficit disorder, mood disorders, and anxiety.
- Encouraging and incentivizing provider use of SBIRT, an evidence-based practice to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs, improving early initiation of treatment.
- Training and incentivizing physical health and behavioral health providers on the use of Z-codes to identify and address social determinants of health and independence that affect the member's total health.
- Promotion of Project ECHO to increase provider knowledge and to amplify local capacity to provide best practice integrated care for our members:
- Consultative behavioral health services for primary care providers
- Comprehensive member assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These service coordination elements help 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 promotes improved mobility

and functional status and allow enrollees to reside in the least restrictive environment possible.

- Assessments and service plans that identify an enrollee's personal and social determinants of health and independence needs, which direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Service Coordinator referrals and predictive modeling software that identify enrollees at increased risk of functional decline, hospitalization, and emergency department visits.

Our service coordination program includes members in cohort groups required by the State and individuals with other conditions that benefit from service coordination, including high-risk members with substance use disorders, women with high-risk pregnancies, infants with neonatal abstinence, and members with chronic pain. All members are eligible for service coordination. Providers referring a member to service coordination are invited to call member services, complete a service coordination referral form that is housed on the website, or make a request through the provider portal.

Integrated Service Coordination (Service Coordination and Disease Management)

We designed our Integrated Service Coordination (ISC) to identify our most complex and vulnerable members with whom we have an opportunity to make a significant difference. We engage these members in integrated service coordination 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.

We encourage autonomy and active self-management of acute and chronic conditions where clinically appropriate with tools and education directed at each member's unique needs and health literacy. A well-trained Service Coordinator serves as the single point of contact for the member. We collaborate with the member/member supports/integrated care team to create a service plan that includes mutually agreed upon member-centered goals and actions for the member/member supports. The Service Coordinator and the care team coordinate both covered and non-covered services 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 social comorbidities.

We assign all members identified as eligible for our Long-Term Services and Supports program and through the KanCare waiver programs a Service Coordinator who will provide service coordination activities with the member and their significant others. This will include a focus on helping the member achieve their health goals, live healthier lives, and reduce or prevent unnecessary institutional care.

The LTSS Service Coordinator completes a comprehensive assessment which is inclusive of home and community-based service needs and works with the member and the interdisciplinary team on developing the PCSP that includes recommendations regarding amount, scope and duration of services. The Service Coordinator works to ensure that signatures occur timely and that the approved, signed plan is distributed to members of the interdisciplinary team within fourteen days of the establishment of waiver eligibility. Service Coordinators work with providers to ensure that required signatures of the PCSP are collected prior to service delivery. Completed PCSP's can be sent to our dedicated email address, AetnaBetterHealthofKSSP@AETNA.com.

The integrated service coordination program is "Integrated" as it reflects our belief that service coordination 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 supports needs. Service coordination staff assists members in coordinating medical and behavioral health services as well as those available in the community or that are not covered in the member's benefits package.

Based on the member's needs, Service Coordinators use condition-specific assessments and service plan interventions to assist with chronic condition management, thereby including traditional "disease management" within the ISC process rather than it being managed separately. Members with diabetes, COPD, heart failure, asthma, depression, chronic kidney disease, bipolar disorder, schizophrenia, arthritis, hepatitis C, cancer, HIV, and coronary artery disease are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk assessments, service coordination assessments, concurrent review/prior authorization referral, as well as member and provider referrals.

Any psychosocial issues and cognitive limitations are incorporated into the individualized service plan as are the cultural practices and beliefs that are most important to the member. We specifically address barriers to improving health and root causes of poor health outcomes to help both the Service Coordinator and the member better understand what has prevented full engagement with a suggested clinical treatment or service plan. Once the member identifies these issues and the care team is informed, truly individualized and collaborative service planning can begin.

The ISC program manages the unique needs of each member's experience. Whether they have short term acute needs, longstanding chronic health issues, or need information, resources, or care coordination we tailor the program to each specific member's situation. Using available information, we employ clinical algorithms and Service Coordinator judgment to recommend a level of integrated service coordination best suited to address the member's needs. **If you have patients that need Integrated Service Coordination or you have any questions about these services, call member services.**

Concurrent Review Overview

Aetna Better Health conducts concurrent utilization review for each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission and appropriateness of the level of care using the MCG® criteria (formerly known as Milliman Care Guidelines). We conduct admission certification within 72 hours of receiving notification. Hospitals must notify us within 48 hours or the next business day (in the event of weekend or holiday considerations) of an unscheduled admission.

We conduct continued stay reviews before the expiration of the assigned length of stay. We notify providers of approval or denial of length of stay. Our staff conducts these reviews. The staff works with the Medical Directors in reviewing medical record documentation for hospitalized members.

We apply the MCG® criteria along with state and federal guidelines to verify consistency in hospital-based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. We update MCG® criteria regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Neonatal Intensive Care Admission – ProgenyHealth

Aetna Better of Health of Kansas uses Progeny Health to conduct utilization review and care management for newborns admitted to the Neonatal Intensive Care Unit or Special Care Nursery. ProgenyHealth provides comprehensive, telephonic neonatal care management services exclusively focused on newborns admitted to the NICU or Special Care Nursery. The program promotes evidence-based best practices and is customized to meet the individual healthcare needs of each infant. During the course of the hospital stay, ProgenyHealth's Clinical Care Nurses work collaboratively with the Hospital's Utilization Management Team. Simultaneously, ProgenyHealth's Nurse Case Managers begin working directly with the families to ensure they are educated, active participants in care delivery.

NICU Admission Notification and Readmissions

Please notify ProgenyHealth of admissions via fax at **1-888-767-0398** and their clinical staff will contact your designated staff to perform utilization management and discharge planning throughout the inpatient stay. Please include the following information in this notification:

- Mother's Name
- Mother's Date of Birth
- Mother's ID Number
- Infant ID Number (if known)
- Your Facility NPI#
- The Attending Physician NPI #

If there is a readmission within the member's first birthday, Progeny will continue to follow that member. After the member's first birthday, whether they are in the NICU or not, they will transition back to Aetna Better Health of Kansas.

NICU Discharge Planning

For NICU discharge planning, Progeny is responsible for the inpatient reviews and their Care Manager will coordinate with Aetna Better Health of Kansas's Care Managers. Any DME, therapy, home health, etc. that is needed for discharge, will be reviewed by the Aetna Better Health of Kansas Prior Authorization Department.

NICU Case Management

Families will have a dedicated Case Manager who provide support and education. Following notifications of NICU admission, Progeny Health outreaches caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to a safe discharge home. ProgenyHealth Case Managers, Social Workers, and Care Coordinators assist members with identifying support and utilize national and local community resources such as: identifying a PCP, Behavioral Health Support, Lactation Services, and Transportation Resources. Direct contact information will be provided for the ProgenyHealth UM and CM nurses once they are assigned to a member in your facility. ProgenyHealth's Case Management team may be reached at ABHKS-CM@progenyhealth.com and their Utilization Review team may be reached at ABHKS-UM@progenyhealth.com.

NICU Utilization Review Peer to Peer and Appeals

ProgenyHealth will follow all Aetna Better Health of Kansas processes and timeframes that are currently in place for notifications and determinations. Verbal notification of Peer-to-Peer process is provided at the time of denial notification, and denial letters are mailed. Peer-to-Peer may be requested with a ProgenyHealth Medical Director by calling **1-888-832-2006**. If a denial determination is upheld, providers should follow the Aetna Better Health of Kansas appeal process.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our concurrent review clinicians work with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning is initiated
- Facilitating or attending discharge planning meetings for members with complex or multiple discharge needs
- Providing hospital staff and attending physicians with names of our providers (i.e., home health agencies, durable medical equipment (DME)/medical supply companies, other outpatient providers)
- Informing hospital staff and attending physicians of covered benefits as indicated
- **Coordination with Member Services to arrange for NEMT services at discharge**

- Collaboration with Service Coordination team who will work with the provider, family and State Transition specialist to ensure thoughtful and detailed discharge planning and safe transitions to the community

Discharge from a Skilled Nursing Facility

All discharges from a Skilled Nursing Facility (SNF) must be coordinated with the member's Service Coordinator. In accordance with federal law, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicaid Title XIX of the Social Security Act. Regardless of the reason, the member, his or her representative, and the member's Service Coordinator must be involved in discharge planning.

CHAPTER 13: PRIOR AUTHORIZATION

[Back to
Table of
Contents](#)

PCPs or treating providers are responsible for initiating and coordinating a member's request for authorization. Providers may contact the Prior Authorization department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with our prior authorization requirements, policies, and request procedures. Providers must obtain a prior authorization number to submit for reimbursement of claims. Aetna Better Health does not prohibit or otherwise restrict providers acting within the lawful scope of their practice from advising or advocating on behalf of an Aetna beneficiary, about the member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered). This includes the provision of sufficient information to provide an opportunity for the member to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency Services

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition to stabilize the patient.

We permit emergency medical services to be delivered in or out-of-network without obtaining prior authorization if the member was admitted for the treatment of an emergency medical condition. Aetna Better Health does not limit what constitutes an emergency medical condition based on diagnoses or symptoms. We do not withhold payment from providers in or out-of-network. However, we encourage notification for appropriate coordination of care and discharge planning. The Prior Authorization department or concurrent review clinician document the notification. Emergency services do not require prior authorization; however, notification is required within 48 hours or the next business day (a consideration for weekend and holidays) if an admission has occurred.

Post-stabilization Services

Post stabilization services means Covered Services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The post-stabilization care services rules set forth at 42 CFR § 422.113(c).

We will limit charges to enrollees for post-stabilization care services to an amount no greater than what we would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

We cover post-stabilization services under the following circumstances without prior authorization, whether or not a network provider provides the services:

- The post-stabilization services were approved by us
- The provider requested prior approval for the post-stabilization services, but we did not respond within one (1) hour of the request
- The provider could not reach us to request prior approval for the services
- Our representative and the treating provider could not reach an agreement concerning the member's care, and our Medical Director was not available for consultation
 - Note: In such cases, we provide the treating provider an opportunity to consult with a Medical Director; therefore, the treating provider may continue with the member's care until a Medical Director is reached or any of the following criteria are met:
 - The provider with privileges at the treating hospital assumes responsibility for the member's care
 - The provider assumes responsibility for the member's care through transfer
 - Us and the treating provider reach an agreement concerning the member's care
 - The member is discharged

Services Requiring Prior Authorization

A link to our Prior Authorization Tool, located on our website

www.AetnaBetterHealth.com/Kansas, lists the services that require prior authorization, consistent with Aetna Better Health's policies and governing regulations. We update the list at least annually and periodically as appropriate. You can also visit www.AetnaBetterHealth.com/Kansas/providers/resources/authorization.

We do not reimburse unauthorized services, and authorization is not a guarantee of payment. All out-of-network services must be authorized.

Exceptions to Prior Authorizations

- Prior authorization for emergency services or post-stabilization services whether provided by an in-network or non-network provider
- Access to family planning services
- Well-woman services by a non-network or in-network provider
- Retroactive eligibility, in which case, a retrospective review will be completed

Provider Requirements

A prior authorization request must include the following:

- Current, applicable codes, which may include:
 - Current Procedural Terminology (CPT)
 - International Classification of Diseases, 10th Edition (ICD-10 CM)
 - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes

- National Drug Code (NDC)
- Name, date of birth, and identification number of the member
- PCP or treating provider
- Name, address, phone and fax number, and signature, if applicable, of the referring provider
- Name, address, phone, and fax number of the consulting provider
- Reason for the request
- Presentation of current objective clinical information, such as clinical notes, laboratory and imaging studies, comorbidities, complications, progress of treatment, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

How to Request Prior Authorizations

A prior authorization request may be initiated by:

- Submitting the request through Availity Web Portal located at <https://apps.availity.com/availity/web/public.elegant.login>.
- Fax the request form to **1-855-225-4102** (form is available on our website: www.AetnaBetterHealth.com/Kansas). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Through our toll-free number: **1-855-221-5656**

To check the status of a prior authorization request you submitted or to confirm we received the request, please visit the Availity Web Portal at <https://apps.availity.com/availity/web/public.elegant.login>, or call us at **1-855-221-5656**. The Availity Web Portal allows you to check status and view authorization history.

If you do not receive a response for non-emergency prior authorization within 14 days, please contact us at **1-855-221-5656**.

Medical Necessity Criteria (Physical and Behavioral Health)

Aetna Better Health uses nationally recognized, community developed, evidence-based criteria, and State criteria to support prior authorization determinations, which are applied based on the needs of individual members and characteristics of the local delivery system. Service authorization staff who make medical necessity determinations are trained on the criteria, which are established and reviewed according to Aetna Better Health policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health uses the following medical review criteria. We review criteria sets annually for appropriateness to Aetna Better Health's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. We consistently apply the criteria, consider the needs of members, and allow for consultations with requesting providers when appropriate. The criteria are consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- KanCare Pharmacy Prior Authorization Clinical Criteria
- Applicable MCG® as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health Clinical Policy Bulletins (CPBs)
- Aetna Better Health Policy Council Review

If MCG® states “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna Better Health CPBs, is consulted and utilized.

For prior authorization of outpatient and inpatient behavioral health services, Aetna Better Health uses:

- Criteria required by applicable State or federal regulatory agency
- KanCare Pharmacy Prior Authorization Clinical Criteria
- MCG-BH, American Society of Addiction Medicine (ASAM)
- Aetna Better Health Clinical Policy Bulletins (CPBs)
- Aetna Better Health Clinical Policy Council Review

Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Criteria for long term services and supports (LTSS) and state plan only services are based on the KDHE-DHCF program benefits. We refer authorizations for LTSS to the member’s assigned Service Coordinator and approval is based on the member’s needs as identified through a comprehensive assessment and as aligned with the LTSS benefits.

Timeliness of Decisions and Notifications to Providers and Members

Aetna Better Health makes prior authorization decisions and notifies practitioners and providers and applicable members in a timely manner unless otherwise required by the State of Kansas. We adhere to the following decision/notification time standards. We verify the availability of appropriate staff between the hours of 8 AM and 5 PM, 7 days per week, to respond to authorization requests within the established timeframes. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements

**Note: For Pharmacy timeframes, please refer to Chapter 15-Pharmacy Management; page 103 Decision and Notification Standards*

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within (72 hours of receipt of the request that includes all	Practitioner/Provider	Oral or Electronic

	necessary clinical information)		
Urgent pre-service denial	Within 72 hours of receipt of the request that includes all necessary clinical information	Practitioner/Provider and Member	Oral or Electronic and Written. Written must be no later than three (3) calendar days after oral notification.
Non-urgent pre-service approval	Within 14 calendar days of receipt of the request	Practitioner/Provider	Oral or Electronic
Non-urgent pre-service denial	Within 14 calendar days of receipt of the request	Practitioner/Provider and Member	Written
Urgent concurrent approval	Within 72 hours of receipt of the request that includes all necessary clinical information	Practitioner/Provider	Oral or Electronic
Urgent concurrent Denial	Within 72 hours of receipt of the request that includes all necessary clinical information	Practitioner/Provider and Member	Written
Post-service approval	Within 30 calendar days of receipt of the request	Practitioner/Provider	Oral or Electronic
Post-service denial	Within 30 calendar days of receipt of the request	Practitioner/Provider and Member	Written
Termination, Suspension, or Reduction of Prior Authorization	At least 10 calendar days before the date of the action	Practitioner/Provider and Member	Written

Prior Authorization Period of Validation

Prior authorization numbers are valid for the dates of service authorized or for a period not to exceed 60 days after the dates of service authorized. This does not apply to transition of care authorizations which are valid up to 90 days. The member must be enrolled and eligible on each date of service.

For information about how to verify member eligibility, please review Chapter 8 in this Manual.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health assigns a prior authorization number which refers to and documents the approval. Aetna Better Health provides notification of the approval or denial to the out-of-network provider within the timeframes appropriate to the type of request.

Occasionally, a provider may refer a member to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health's Medical Director.

Aetna Better Health will permit American Indian Members to obtain covered services from non-participating Indian Health Center Providers (IHCP's) from whom the member is otherwise eligible to receive such services. Aetna Better Health will permit a non-participating IHCP to refer an American Indian Member to a participating provider

Notice of Action Requirements

Aetna Better Health provides the provider and the member with written notification [i.e., Notice of Action (NOA)] of any decision to deny, reduce, suspend, or terminate a prior authorization request, or to authorize a service in the amount, duration, or scope less than requested or deny payment, in whole or part, for a service.

The NOA includes:

- The action Aetna Better Health has or intends to take and the effective date of that action
- The specific reason for the action, customized to the member circumstances, and in easily understandable language
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that, upon request, the practitioner/provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeal process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The right of the member or practitioner/provider (with written permission of the member) to request a State Fair Hearing and instructions about how to request a State Fair Hearing
- A description and the circumstances under which an expedited appeals process and resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the

appeal or pending a State Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services

- Translation service information
- The procedures for exercising the rights specified in this section

Aetna Better Health gives an NOA by the date of the action for the following circumstances including:

- The death of a member
- A signed written member statement requesting termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information)
- The member's admission to an institution where he/she is ineligible for further services
- The member's address is unknown, and mail directed to him/her has no forwarding address.
- The member is accepted for Medicaid services by another local jurisdiction
- The member's physician prescribes the change in level of medical care
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions
- The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers)

Aetna Better Health gives a NOA on the date of action when the action is a denial of payment.

Aetna Better Health gives an NOA at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five days if probable member fraud has been verified.

Continuation of Benefits

For Non-Waiver Services, Aetna Better Health continues member's benefits during the appeal process if:

- The member requested continuation of benefits in writing within 10 days of the date of the NOA for those eligible who requested the State Fair Hearing Process or the intended effective date of the proposed action
- The member or provider files the appeal within 60 calendar days (3 calendar days are allowed for mailing time) of the date on the notice of adverse benefit determination, or you file the State Fair Hearing request within 120 calendar days (3 calendar days are allowed for mailing time) of the date on the appeal resolution letter.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment

- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal

For Waiver Services, Aetna Better Health continues member's benefits during the appeal process if:

- The member or provider files the appeal within 60 calendar days (3 calendar days are allowed for mailing time) of the date on the notice of adverse benefit determination, or you file the State Fair Hearing request within 120 calendar days (3 calendar days are allowed for mailing time) of the date on the appeal resolution letter.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal

Aetna Better Health continues the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A State Fair Hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Other Insurance

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance, such as a commercial carrier, Aetna Better Health will coordinate payment of benefits in accordance with the terms of the contract and federal and state requirements.

Aetna Better Health is the payer of last resort, unless specifically prohibited by State or Federal law. This means that Aetna Better Health will be a source of payment for covered services only after all other sources of payment have been exhausted. Aetna Better Health will take reasonable measures to identify potentially legally liable third-party sources.

Cost Avoidance

Aetna Better Health will take reasonable measures to determine all legally liable parties - any individual, entity, or program that is or may be potentially liable to pay all or part of the expenditures for covered services. Aetna Better Health will cost avoid a claim if it has established the probable existence of a liable third-party at the time the claim is filed. For purposes of cost avoidance, establishing probably liability takes place when Aetna Better Health receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a

member. If we do not establish the probable existence of a party's liability, Aetna Better Health will adjudicate the claim for payment. Aetna Better Health will then utilize post-payment recovery, described in further detail below, if it turns out a legally liable third-party is responsible for payment of covered services.

If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance, or deductible, Aetna Better Health Kansas is responsible for making these payments.

Coordination of Benefits

Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit.

When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment.

Note: Aetna Better Health follows KMAP TPL policy. All KMAP TPL billing requirements still apply. Please refer to current up to date KMAP General TPL Payment provider manual found at: www.kmap-state-ks.us/Public/providermanuals.asp.

CHAPTER 14: QUALITY MANAGEMENT

[Back to Table of Contents](#)

Overview

Our Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. We use this approach to measure conformance with desired medical standards and develop activities designed to improve member outcomes.

We perform QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of members or maintain current health status when the member's condition is not amenable to improvement.

Our QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM processes enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of data in the monitoring, measurement, and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization, and committees from the Board of Directors to the Member Advisory Committee. This structure allows members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. Our QM department and the Quality Management Oversight Committee (QMOC) and subcommittees support the Medical Director in this effort.

The QMOC's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee provides executive oversight of the QAPI program, makes recommendations to the Board of Directors about our quality management and performance improvement activities, and makes sure the QAPI is integrated throughout the organization among all departments, delegated organizations, and our providers. Major functions of the QMOC Committee include:

- Confirm that quality activities improve the quality of care and services provided to members
- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators, and satisfaction surveys
- Advise and make recommendations to improve health plan operations
- Review and evaluate company-wide performance monitoring activities including service coordination, customer service, credentialing, claims, grievance and appeals, prevention and wellness, provider relations, and quality and utilization management

Additional committees such as Service Improvement, Credentialing and Performance, Appeals/Grievance, Quality Management and Utilization Management further support our QAPI Program. We encourage provider participation on key medical committees. Providers may contact the Medical Director or inform their provider experience representative if they wish to participate.

Our QM staff develops and implements an annual work plan which specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation which assesses the impact and effectiveness of QM activities.

Our QM department is an integral part of the health plan. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards and recommend and promote improvements in the delivery of care and service to our members. Our QM and Medical Management departments maintain ongoing coordination and collaboration regarding quality initiatives, service coordination, and disease management activities involving the care of our members.

Our QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, we, in collaboration with providers, monitors and continually assess the quality of services provided to our members. Providers are obligated to support and our QAPI and utilization management program standards.

Note: Providers must participate in the CMS and Aetna Better Health quality improvement initiatives. Any information provided must be reliable and complete.

Identifying Opportunities for Improvement

Aetna Better Health identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna Better Health monitors to identify opportunities for quality improvements include:

- Formal Feedback from External Stakeholder Groups: We take the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys [Consumer Assessment of Healthcare Providers and Systems

(CAHPS)] or focus groups with individuals such as members and families, providers, and state and community agencies.

- Findings from External Program Monitoring and Formal Reviews: Externally initiated review activities, such as annual external quality program assessments or issues identified through a State's ongoing contract monitoring oversight process assist us in identifying specific program activities/processes needing improvement.
- Internal Review of Individual Member or Provider Issues: In addition to receiving complaints, grievances, and appeals from members, providers, and other external sources, we proactively identify potential quality of service issues for review through daily operations (i.e., member services, prior authorization, and service coordination). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our service coordination processes, access to provider care and covered services, and quality of care), we identify specific opportunities for improving care delivered to individual members.
- Findings from Internal Program Assessments: We conduct several formal assessments/reviews of program operations and providers used to identify opportunities for improvement. This includes, but is not limited to, record reviews of contracted providers, credentialing/recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.
- Clinical and Non-Clinical Performance Measure Results: We use an array of clinical and non-clinical performance standards (e.g., call center response times and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, we identify opportunities for improvement in clinical and operational functions. These measures include:
 - Adherence to nationally recognized best practice guidelines and protocols
 - Prior authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
 - Provider availability and accessibility, including:
 - Length of time to respond to requests for referrals
 - Timeliness of receipt of covered services
 - Timeliness of the implementation of members' care plans
 - Availability of 24/7 telephonic assistance to members and caregivers receiving home care services
- Data Trending and Pattern Analysis: With our innovative information management systems and data mining tools, we make extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- Other Service Performance Monitoring Strategies: We use numerous monitoring processes to confirm effective delivery of services to our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that we monitor include, but are not limited to:
 - High-cost, high-volume, and problem prone aspects of the long-term care services our members receive

- Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member’s informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization
- Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) Concerns

Aetna Better Health has a process for identifying PQoC concerns related to our provider network including researching and resolving these care concerns in an expeditious manner and following up to make sure providers implemented needed interventions. This may include referring the issue to peer review and other appropriate external entities. In addition, we track and trend PQoC cases and prepares trend reports organized according to provider, issue category, referral source, number of verified issues, and closure levels. We use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Credentialing and Performance Committee or identify the need for possible quality improvement initiatives.

Performance Improvement Projects (PIPs)

We design our PIPs, a key component of our QM Program, to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs follow CMS protocols. We participate in state-mandated PIPs and selects PIP topics that:

- Target improvement in areas that address a broad spectrum of key aspects of members’ care and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect our enrollment in terms of demographic characteristics, prevalence of disease, and potential consequences (risks) of the disease

PIP proposals prepared by our QM department are reviewed and approved by our Medical Director, Quality Management/Utilization Committee and the Quality Management Oversight Committee (QMOC) prior to submission to KDHE for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units, as well as from providers who participate in our QM/UM Committee.

The QM department conducts ongoing evaluation of study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, we immediately conduct additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies

should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer Review

The Credentialing and Performance Committee evaluates peer review activities. This committee may act if they identify a quality issue. Such actions may include, but are not limited to, development of a Corrective Action Plan (CAP) with timeframes for improvement, evidence of education, development of policies and procedures, monitoring and trending of data, or discontinuation of the provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, as well as other quality issues.

Although the Quality Management department coordinates peer review activities, they may require the participation of Utilization Management and Service Coordination, Provider Relations, or other departments. We may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plan's peer review process adheres to our policies as well as applicable state and federal laws and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in our network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

Performance Measures

We collect and report clinical and administrative performance measure data to the Kansas Department of Health and Environment. The data enables us and KDHE to evaluate our adherence to practice guidelines, as applicable, and improvement in member outcomes. We also may collect older records for current members who may have been a member of another managed care organization.

Satisfaction Survey

Aetna Better Health conducts member and provider satisfaction surveys to gain feedback regarding members' and providers' experiences with quality of care, access to care, and service/operations. We use member and provider satisfaction survey results to help identify opportunities and implement improvement. We describe each survey below.

Member Satisfaction Surveys

CAHPS are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Children) are subsets of HEDIS reporting. We contract with a NCQA-certified vendor to administer the survey according to HEDIS and

CMS survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

Provider Satisfaction Surveys

Aetna Better Health conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and our response to inquiries.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act. States are to contract with an independent external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to members. We make the results of the EQR available upon request to specified groups and to interested stakeholders.

We cooperate fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by KDHE. We assist in the identification and collection of any data or records to be reviewed by the independent evaluation team. We also provide complete records to the External Quality Review Organization (EQRO) in the timeframe allowed by the EQRO. We require our contracted providers to provide any records that the EQRO may need for its review.

We share the results of the EQR with providers and incorporate them into our overall QM and medical management programs as part of our continuous quality improvement process.

Provider Profiles

To promote the provision of quality care, we profile providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for specific profiling measures. Individual providers and practices are profiled for multiple measures, and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program shares standardized utilization data with physicians to improve clinical outcomes. Our profiling program supports clinical decision-making and patient engagement as providers often have little access to information about how they are managing their members or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider-patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

We include several measures in the provider profile, which include but are not limited to:

- Frequency of individual patient visits to the PCP
- EPSDT services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (i.e., appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications

CHAPTER 15: PHARMACY MANAGEMENT

[Back to Table of Contents](#)

Pharmacy Management Overview

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for a member. We use CVS/Caremark for pharmacy benefit management services. CVS/Caremark provides members access to a retail pharmacy network and other services including claims processing, mail order, and a specialty pharmacy program.

K-TRACS

Effective 04/01/2023, Medicaid providers that are required to check the Kansas Prescription Drug Monitoring Program (PDMP), also known as K-TRACS, prior to writing a controlled substance medication for a Medicaid beneficiary/member, will be required to submit an annual attestation form acknowledging their awareness of and compliance with our PDMP related policies. The form may be located at the following address:

<https://forms.office.com/g/EYLRuUQ4Mj>

E-Prescribing

E-prescribing is the transmission, using electronic media, of a prescription or prescription-related information, between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network such as Surescripts. We provide member eligibility and coverage status, medication history, and formulary information to providers who use e-prescribing tools.

Formulary/Preferred Drug List (PDL)

Aetna Better Health adheres to the Kansas Medicaid PDL and can be viewed at <https://www.kdhe.ks.gov/DocumentCenter/View/420/Preferred-Drug-List-PDF?bidId=> or by visiting the KDHE website for the PDL and clinical criteria. You can use our on-line formulary search tool to validate drug coverage information, such as preferred status, prior authorization (PA), and quantity level limits (QLL). You can also download a print version of our formulary/PDL from the website. When prescribing medications and over the counter drugs, check the coverage status of the drug to identify any restrictions or limitations. For drugs on the formulary/PDL that require prior approval, there are pharmacy PA request forms available on our website. If you do not have access to the internet, you may contact us telephonically or by fax to submit a PA request or have a PA form mailed to your office. If a drug is not listed on our formulary/PDL, a Pharmacy PA Request form must be completed before an exception to the formulary/PDL is considered. Please include supporting medical records that assist with the review of the exception and PA request.

We update the formulary/PDL posted to our website on a monthly basis or more frequently as applicable. Please visit the Aetna Better Health website at

<https://www.aetnabetterhealth.com/kansas/pharmacy-prescription-drug-benefits.html>

pharmacy page to view the most recent formulary/PDL updates and access our up-to-date formulary search tool.

Quantity Level Limits (QLL)

Quantity Level Limits (QLL) apply for certain medications to promote the safe and appropriate use of these medications. QLLs are developed based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat. Review the formulary/PDL on-line search tool to determine if a prescribed medication has a QLL. To request an exception to the QLLs, submit a PA request by calling our Pharmacy PA team at **1-855-221-5656** select *, then say “Authorization”, then say “Pharmacy”, faxing the request to **1-844-807-8453**, or by submitting an electronic PA request through the health plan website

<https://www.aetnabetterhealth.com/kansas/providers/pharmacy-prior-authorization.html>

Prior Authorization Process

Certain medications listed on the formulary/PDL require PA to make sure they are utilized appropriately prior to the dispensing of those medications. There may also be a need for a prescribed drug that is not listed on the formulary/PDL. In those instances, a provider may make an exception request for coverage of a non-formulary/non-preferred drug. Typically, we require providers to obtain PA/exception approval prior to prescribing or dispensing for the following drugs:

- Select specialty medications, including injectables and oral medications
- Non-formulary/non-preferred drugs not excluded under a State’s Medicaid program
- Prescriptions that do not conform to our evidence-based utilization practices (e.g., QLLs, age restrictions, or ST)
- Brand name drug requests, when an “A” rated generic equivalent is available

To request a PA, the prescribing provider can contact Aetna Better Health Pharmacy Prior Authorization Department, at **1-855-221-5656**, select *, then say “Authorization”, then say “Pharmacy”, submit a fax request to **1-844-807-8453**, or submit an electronic PA through the health plan website <https://www.aetnabetterhealth.com/kansas/providers/pharmacy-prior-authorization.html> 24 hours per day; calls should be placed from 8 AM – 5 PM, Monday through Friday. In the event of an immediate need after business hours, the call should be made to Member Services at **1-855-221-5656**, option 1.

Prescribing providers can download the drug specific PA form or general pharmacy PA forms from the health plan website. To support the timely review of a PA request, prescribers are asked to supply the following information:

- Member’s name, date of birth, and identification number
- Prescribing practitioner’s/provider’s name, and telephone and fax numbers
- Medication name, strength, frequency, quantity, and duration
- Diagnosis for which medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (e.g., non-formulary drug, age limit, QLL, or ST override, generic override, or vacation override)

The prescribing provider and member are notified of all decisions in accordance with regulatory requirements and timelines. Prior to making a final decision, we may contact the prescriber to discuss the case or consult with a board-certified physician from an appropriate specialty area such as a psychiatrist. In the event that a PA or exception request has an adverse determination, the prescribing provider may contact the issuing Medical Director/Pharmacist to discuss the decision by calling our Pharmacy Prior Authorization at **1-855-221-5656**, select *, then say “Authorization”, then say “Pharmacy”.

Decision and Notification Standards

Aetna Better Health makes pharmacy PA and/or exception (if applicable) decisions and notifies practitioners/providers, and/or members in a timely manner, according to the standards defined below:

- Decision of approval, denial or request for information for urgent pre-service authorization requests are completed within twenty-four (24) calendar hours of receipt
- Decision of approval, denial or request for information for non-urgent pre-service authorization requests are completed within twenty-four (24) calendar hours of receipt Aetna Better Health notifies requesting practitioners/providers by fax, phone or electronic communication of the approved decision within twenty-four (24) calendar hours of receiving all necessary information
- If an authorization is denied, Aetna Better Health gives requesting practitioners/providers and members electronic or written confirmation of the reason for the decision with information about their appeal rights and appeal process including how to initiate an expedited appeal
- Aetna Better Health will fill qualifying prescriptions for a seventy-two (72) hour supply for physical health medications and 5-day supply for behavioral health medications if the member’s prescription has not been filled due to a pending prior authorization decision, if dispensing pharmacists deems appropriate

Mail Order Prescriptions

Aetna Better Health offers mail order program for non-specialty maintenance medications through CVS/Caremark mail service. This program allows members to receive a 90-day supply of certain prescription medications. If you have a member who may benefit from our mail order program and would like more information on our program, visit our health plan website at <https://www.aetnabetterhealth.com/kansas/pharmacy-prescription-drug-benefits.html>

PBM Claim Processing Information

Members may have other primary prescription coverage that require use of alternate RXBIN and RXPCN as provided below for coordination of benefit billing.

If the Primary is...	If the Secondary is...	RXBIN	RXPCN	RXGRP
Aetna Better Health of Kansas	N/A	610591	ADV	RX8849

Other Medicare Part B or Part D Plan	Aetna Better Health of Kansas	012114	COBADV	RX8849
Other Commercial Plan	Aetna Better Health of Kansas	013089	COMSEGADV	RX8849

CHAPTER 16: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

[Back to Table of Contents](#)

We require providers to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST) and the Kansas Advance Directive Health Care Act, including all other federal and state laws regarding advance directives for adult members.

Advance Directives

Aetna Better Health of Kansas maintains written policies and procedures related to advance directives that describe the provision of health care for an incapacitated member. These policies promote the member's ability to make known his/her preferences about medical care before they faced a serious injury or illness.

We define advance directives as a legal document through which a person may provide directions or express preferences concerning his/her medical care and to appoint someone to act on his/her behalf. Physicians and others use advance directives when a person is unable to make or communicate decisions about his/her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes someone to be unable to actively decide about his/her medical care.

The advance directive policy details our obligations with respect to all adult individuals receiving medical care by or through us. These obligations by both federal and state laws include, but are not limited to:

- Before implementing a healthcare decision made for a member, a supervising healthcare provider, if possible, will communicate to the member the decision made and the name of the person making the decision.
- A supervising provider who knows of the existence of an advance directive, a withdraw of an advance directive, or a termination of the named person making decisions on the behalf of the member will promptly record its existence in the member's medical record and, if in writing, will request a copy and, if one is furnished, will arrange for its update in the medical record.
- A PCP who makes or is informed of a determination that a member lacks or has recovered capacity, or that another condition exists which will affect an individual instruction or the authority of an agent, guardian, or surrogate, will promptly record the determination in the member's medical record and communicate the determination to the member, if possible, and to any person then authorized to make healthcare decisions for the member.
- Except when a provider declines to comply with an individual instruction or healthcare-related decision as described below, a provider or institution providing care to a member must:

- Comply with an individual instruction of the member and with a reasonable interpretation of that instruction made by a person then authorized to make healthcare decisions for the member.
 - Comply with a healthcare decision for the member made by a person then authorized to make healthcare decisions for the member to the same extent as if the member had made the decision while having capacity.
- A provider can decline to comply with an individual instruction or healthcare decision for reasons of conscience. A healthcare institution may decline to comply with an individual instruction or healthcare decision if contrary to a policy of the institution expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make healthcare decisions for the patient.
- A provider or institution may decline to comply with an individual instruction or healthcare decision that requires medically ineffective healthcare or healthcare contrary to generally accepted healthcare standards applicable to the healthcare provider or institution.
- A provider or institution that declines to comply with an individual instruction or healthcare decision will:
 - Promptly inform the member, if possible, and any person authorized to make healthcare decision on their behalf continuing care until transfer.
 - Immediately make all reasonable efforts, if member or authorized representatives are not already doing so, to assist in the transfer to another provider or institution willing to comply with the instructions and or decision.

A provider or institution may not require or prohibit the execution or revocation of an advance directive as a condition for providing healthcare. Providers and institutions must comply with the following:

- Maintain written policies and follow certain procedures with respect to advance directives
- Document in the member's medical record whether or not the patient has executed an advance directive (including a psychiatric advance directive)
- Provide Aetna with a copy of the executed advance directive once received
- Comply with all federal and state laws regarding advance directives (this includes complying with any state law on psychiatric advance directives)
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This does not mean, however, that a provider is required to provide care that conflicts with an advance directive.
- Inform the individual that complaints concerning implementation of these advance directive requirements may be filed with the state agency that surveys and certifies Medicaid providers
- Provide staff and community education on issues related to advance directives

Visit the following site for more information on both federal and Kansas specific advanced directive information. <https://www.nrc-pad.org/images/stories/PDFs/fedaddirectives2a.pdf>

Proxy Directive

A proxy directive (durable power of attorney for health care) is a document the member will use to appoint a person to make healthcare decisions for them in the event they become unable to make them on their own. This document goes into effect whether the member's inability to make healthcare decisions is temporary because of an accident or permanent because of a disease. The person the member will appoint is known as their "healthcare representative". They are responsible for making the same decisions the member would have made under the circumstances. If they are unable to determine what the member would want in a specific situation, they are to base their decision on what they think is in the member's best interest.

Instruction Directive

An instruction directive (living will) is a document the member uses to tell their doctor and family about the kinds of situations they would want or not want to have life-sustaining treatment in the event they are unable to make their own healthcare decisions. The member can also include a description of their beliefs, values, and general care and treatment preferences. This will guide their doctor and family when they must make healthcare decisions for the member in situations not specifically covered by their advance directive.

Advance directives are important for everyone to have, no matter what their age or health condition is. They let the member say what type of end of life care they do and do not want.

- Kansas Law authorizes the form
- The person must be at least 18 and competent when signing a living will
- There must be a witness at least 18 years of age who is not related to the person by blood, marriage, or adoption and they cannot have financial interest in the personal medical care
- The Living Will only applies when the person is diagnosed and certified as terminally ill by at least two doctors
- The Living Will does not apply to a person in a coma or vegetative state, unless the person is diagnosed with a terminal illness
- Pain relief or comfort care can be given with the Living Will

We advise our members of the following if they have an advance directive:

- Keep a copy of your advance directive for yourself
- Also give a copy to the person you choose to be your medical power of attorney
- Give a copy to each one of your providers and tell them to put a copy in your medical records
- Take a copy with you if you must go to the hospital or the emergency room
- Keep a copy in your car if you have one

We also advise our members that we can help them find a provider that will carry out their advance directive instructions. They can talk to their provider if they need help or have

questions. We also advise that their doctor cannot discriminate against them based on their choice to have or not have an advance directive. We also advise that their doctor cannot base the decision of treatment on whether or not the member chooses to have an advance directive. Providers in our network must follow state laws regarding advance directives. If a member feels the need to file a complaint, we provide them information on how to do so in our Member Handbook. We will educate staff and providers on advance directives at least once a year.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept, or refuse should they become unable to make those decisions later due to illness.

The PSDA requires all healthcare agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. We require our providers to comply with this act.

For additional information about the PSDA, please visit <https://www.gapna.org/patient-self-determination-act-psda>

Transportable Physician Orders for Patient Preferences (TPOPP)

Transferable Physician Orders for Patient Preferences (TPOPP) is based on the belief that every person has the right to make their own decisions regarding their healthcare. The TPOPP initiative improves the quality-of-care people receive at the end of their life.

TPOPP is modeled after the Physician Orders for Life Sustaining Treatment (POLST) paradigm. More than 45 efforts are currently under way to address these important issues in the country. For more information about these efforts, please refer to www.POLST.org.

TPOPP aims to improve the communication of a person's wishes regarding life-sustaining treatments and medical care. To accomplish that aim, TPOPP:

- Obtains and documents a person's preferences regarding resuscitation and the use of mechanical intervention for breathing/ventilation along with other life-sustaining treatment such as tube feedings, etc.
- Translates those preferences into a set of actionable physician orders
- Communicates the person's care preferences across health settings by transporting these physician orders
- Reduces excessive documentation while complying with state laws and the Federal Patient Self-Determination Act

To learn more about the Kansas' POLST program, please visit the below website:
www.polst.org/programs-in-your-state/

For additional information please visit:

www.polst.org/frequently-asked-questions-for-patients/

We require providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the POLST program. The POLST protocol requires a healthcare professional to discuss available treatment options with seriously ill members (or their advocate/family member) and the members preferences are documented on a standardized medical form the member keeps with them.

A member's attending provider or advanced practice staff must sign the form. This form must become part of a member's medical record, as this form will follow the member from one health care setting to another, including hospital, home, nursing home, or hospice.

CHAPTER 17: BILLING AND CLAIMS OVERVIEW

[Back to Table of Contents](#)

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable federal and state laws, rules, and regulations. We do not pay claims submitted by a provider not participating in the KanCare Medicaid Program or excluded from any program under federal law.

We use our business application system to process and adjudicate claims. We accept both Professional- CMS 1500 and Institutional-UB04 electronic and paper claims submissions. To assist us in processing and paying claims efficiently, accurately, and timely, we encourage providers to submit claims electronically. To facilitate electronic claims submissions, we have developed a business relationship with Change Healthcare and Office Ally, Inc. We receive electronic claims through our claims processing system directly from our clearinghouses, process them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then upload them into our business application each business day. Within 24 hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission. For vendor claim submission details, please see the billing section in the below chapter.

Billing and Claims Overview

We process claims in accordance with Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Providers must also use the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in rejection of the diagnoses in the Risk Adjustment Processing System. Important notes: The ICD-10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory, and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.

- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should indicate all diagnoses addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

Please visit the below link to locate information about codes, edits, units, and rates required for correct billing in the state of Kansas:

<https://www.kmap-state-ks.us/public/provider.asp>

Information on Billing and Claim Submission

Timely Filing of Claims

In accordance with contractual obligations, providers must submit claims for services provided to a member in a timely manner. Our timely filing limitations are as follows:

- New claims must be submitted within 180 calendar days from the date of services.
- Corrected claims must be submitted 365 days from the date of service.
- Claims with TPL (or coordination of benefits) should be submitted within 180 days from primary insurer's EOB date or 180 days from date of service, whichever is later.

Failure to submit claims within the prescribed time period may result in payment delay or denial.

There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's Explanation of Benefits.
- Cases where a member has retroactive eligibility. In situations of enrollment in Aetna Better Health with a retroactive eligibility date, the time frames for filing a claim will begin on the date that we receive notification from the enrollment broker of the member's eligibility/enrollment.

Claims Automatically Crossed Over

- Medicare Part B will automatically cross over claims for professional services when the following criteria are met:
 - You file Medicare claims to the appropriate regional carrier for Kansas.
 - Medicare covers the services.
 - The member's ID number is identified on the Medicare claim form in the "Other Insurance" field (Box 9a on the CMS-1500 claim form).
 - There may be exceptions on the forms used based on the Kansas guidelines.

We notify you on the explanation of Medicare benefits (EOMB) that the claim was automatically crossed over for Medicaid processing.

How to File Electronic Claims

Billing

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable federal and state laws, rules, and regulations. We do not pay claims submitted by a provider not enrolled as a provider in the KanCare Medicaid Program or excluded from any program under federal law. Providers have a variety of ways to submit claims:

For ALL claims:

KMAP Portal	Electronically through KMAP front end billing www.kmap-state-ks.us/provider/security/logon.asp
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For Medical Submissions (Claims that are not Dental, Vision or Non-Emergency Transportation Claims):

Claims (Professional-CMS 1500 and Institutional-UB04)	
Electronic Portal (Professional-CMS 1500 and Institutional-UB04)	<p>Availity Web Portal Web Portal: https://apps.availity.com/availity/web/public.elegant.login</p> <p>Our clearinghouses can be accessed through the Availity Web Portal. For specific clearinghouse information, please see Change Healthcare and Office Ally Inc. details below.</p>
Professional-CMS 1500 only Electronic Clearinghouse – Change Healthcare	<p>Change Healthcare www.changehealthcare.com</p> <ul style="list-style-type: none"> • Includes Claim Submissions for: Professional-CMS 1500 claims that are Medicaid primary • Excludes Claim Submissions for: Professional-CMS 1500 claims that are: <ul style="list-style-type: none"> - Medicaid tertiary - All Institutional-UB04 claims <p>Payer ID's: 128KS (Claim Submission) and ABHKS (Real-Time)</p> <p>Note: Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Change Healthcare</p>

Professional-CMS 1500 and Institutional UB04 Electronic Clearinghouse –Office Ally	Office Ally Inc. www.officeally.com except: <ul style="list-style-type: none"> • Claims where Medicaid is the third payer (tertiary claims) <p>Payer ID: 128KS</p> <p>Note: Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Office Ally Inc.</p>
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For Vendor submissions, please see below:

American Dental Association ADA Dental Claim Form	For Electronic Claim Submissions:
Dental	<p>Electronic Submissions:</p> <ul style="list-style-type: none"> • SKYGEN’s Provider Portal: https://pwp.sciondental.com/PWP/Landing • Change Healthcare: www.changehealthcare.com • DentalXChange: www.dentalxchange.com <p>Payer ID: SCION</p> <p>Note: The clearinghouses cannot accept and convert paper ADA claims for electronic submission. The provider offices would need to submit the claim data to the clearinghouse from their practice software. Also, SKYGEN’s provider portal supports secondary and tertiary dental claims.</p>
Vision	<p>Electronic Submissions: Through SKYGEN’s Provider Portal https://ocularbenefitspwp.wonderboxsystem.com</p> <p>Or through:</p> <ul style="list-style-type: none"> • Avality www.avality.com • Waystar www.waystar.com (formerly known as ZirMed) • Change Healthcare www.changehealthcare.com <p>Payer ID: L0140</p> <p>For information about services that should be billed to SKYGEN vs. Aetna Better Health, please visit SKYGEN’s</p>

	<p>Secure Provider Web Portal https://ocularbenefitpwp.wonderboxsystem.com</p> <p>to view the Vision Benefit and Authorization Requirements document , or call SKYGEN directly at 1-855-918-2258.</p>
Transportation	<p>Electronic Submissions: Through Access2Care: www.access2care.net/transportation-providers</p>

How to File a Paper Claim

1) Select the appropriate paper claim form (refer to the table below).

Service	Claim Form
Medical, ambulatory surgical centers, and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing, and emergency room services	UB-04 Form

You can find instructions on how to fill out the claim forms on our website at www.AetnaBetterHealth.com/kansas

- 2) Complete the claim form.
- a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary. Note: Handwritten claim forms are accepted but must be legible.
 - b) We may reject the claim form unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in us denying the claim for untimely filing upon resubmission. If your claim is denied for untimely filing, you will need to submit proof of timely filing to have the claim considered.
- Note: Please submit the letter that was sent with the rejection as this can prevent the resubmitted claim from being denied for untimely filing.**
- 3) Submit original copies of claims through the mail (do NOT fax). To include supporting documentation, such as member’s medical records, clearly label and send to Aetna Better Health of Kansas, at the address below.

For Paper Medical Submissions (Claims that are not Dental, Vision or Non-Emergency Transportation Claims):

Claims (Professional-CMS 1500 and Institutional-UB04)	
Paper Submission (Professional-CMS 1500 and Institutional-UB04)	Paper Claims Mail to: Aetna Better Health of Kansas P.O. Box 982961 El Paso, TX 79998-2961

For Vendor submissions, please see below.

For Paper Claim Submissions:

American Dental Association ADA Dental Claim Form	
Dental	Paper Claims: Aetna Better Health of Kansas - Claims P.O. Box 359 Milwaukee, WI 53201
Vision	Paper Claims: Aetna Better Health of Kansas - Claims P.O. Box 1607 Milwaukee WI 53201
Transportation	For paper submissions: Access2Care, LLC 6363 Fiddler's Green Circle, Ste. #1400 Greenwood Village, CO 80111

Coordination of Benefits

Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit.

When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment. **Please refer to the billing instruction above.**

Specific Claim Type Instructions

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use UB-04 Form.

Home Health Claims

Providers submitting claims for Home Health should use CMS 1500 Form. RHC and FQHC must bill on a CMS 1500 Form.

Durable Medical Equipment (DME) Rental Claims

Use CMS 1500 Form when submitting claims for Durable Medical Equipment (DME) rental.

We only pay DME rental claims up to the purchase price of the DME.

Units billed for the program equal 1 per month. \Units billed for Medicaid equal the number of days billed. Since appropriate billing for CMS is 1 unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from date and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission

Use UB-04 Form when submitting claims for inpatient facilities.

There may be occasions where a member is discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with 24 hours.

Example: Discharge Date: 10/2/10 at 11:00 AM
Readmission Date: 10/3/10 at 9:00 AM

Since the readmission was within 24 hours, this is considered a same day readmission per above definition.

Coding Overview

Aetna Better Health General Claims Payment Information

We always pay claims in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers are paid in accordance with Medicaid claim processing rules.

Correct Coding Initiative

Aetna Better Health follows Medicaid Correct Coding Initiative (CCI) logic, and we perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please visit <https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html>

Note- National codes are not necessarily the same as Kansas rules. Each state has their own set of rules and variations, as approved by CMS.

We also utilize Claim Check as our comprehensive code auditing solution to assist payers with proper reimbursement. CCI guidelines are followed in accordance with Kansas Medicaid state supplied editing. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share the claim auditing rules and clinical rationale inherent in ClaimCheck with our providers.

Providers have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. We consider a service integral to a procedure bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect Coding

Examples of incorrect coding include:

- “Unbundling” – Fragmenting one service into components and coding each as if it were a separate service
- Breaking out bilateral procedures when one code is appropriate
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

You must bill a modifier to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Distinct Procedural Services:** Modifier 59 can be used for a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be used on E&M service codes or on code 77427.
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:** This modifier can be used to indicate that an E&M service is significant and separately identifiable from the other services performed on the same day. This modifier can only be submitted with E&M codes. Documentation in the patient's medical record must support the use of this modifier.

- **Modifier 50 – Bilateral Procedure** – When a procedure is identified as one that can have modifier 50 added to the base code when performed bilaterally, bill the procedure code as a single line item on the claim form with modifier 50 and units of service equal to one. When a code states ‘unilateral’ or ‘bilateral’ in the description, do not add modifier 50. In this instance, the base code is billed only once on the claim and the number of units is one.
- **Modifier 57 – Decision for Surgery:** Modifier 57 indicates an E&M service resulted in the initial decision to perform surgery either the day before a major surgery (90-day global period) or the day of a major surgery (90-day global period). Modifier 57 can only be used on E&M codes.

Please refer to your CPT Manual or KMAP for further detail on all Medicaid allowable modifier usage.

Claims Payment Integrity Reviews

Cotiviti Payment Integrity Reviews:

Aetna Better Health of Kansas (ABH) has partnered with Cotiviti to conduct prepayment and post payment reviews of our claims to further enhance our payment integrity program. Cotiviti will conduct datamining to review of claims after payment has been made to the provider. Cotiviti is reviewing claim payment accuracy regarding Aetna clinical and payment policies, national correct coding standards (CMS, Medicaid.Gov, AAPC, etc.), and provider contracts. When Cotiviti identifies an overpayment, a letter with a description of the overpayment as well as member and claim details will be sent to the provider.

Cotiviti will also conduct DRG Complex Chart Validation (CCV) reviews. DRG reviews offers retrospective, inpatient documentation, coding and clinical validation reviews in accordance with ABH policies as well as national coding guidelines and standards including CMS Program Integrity Manual, ICD-10 CM and PCS Codebooks, ICD-10 CM and Official Coding Guidelines, Coding Clinics, medical literature, and consensus statements. Medical records are requested by Cotiviti, and providers are notified in writing of changes in coding that result in a revision of the DRG assignment and reimbursement.

Cotiviti will conduct a COB (Coordination of Benefits) retrospective review of primary claim payments made by the plan in which another entity should have had primary responsibility. Medicaid is considered the payer of last resort, meaning Medicaid will pay secondary to all other plans for services covered by the other plan. If we identify a claim which was incorrectly processed as primary, a letter with a description of the overpayment as well as member and claim details will be sent to the provider.

Equian Payment Integrity Reviews:

Aetna Better Health of Kansas has contracted with Equian and Cotiviti to conduct review claims for proper coding of facility claims against the final itemization bill to ensure that proper payment is being made in accordance with our contracts, national coding guidelines,

and nationally accepted billing guidelines. You can locate national coding guidelines and nationally accepted billing guidelines and state policies by going to CMS.gov, KDHE.org or other nationally recognized correct coding organizations. In addition, Equian and Cotivity will conduct a post payment review to include the identification of claim overpayments including retro-terminations by utilizing data mining techniques to validate claim payments for facility and professional claims against provider contracts, Aetna Better Health of Kansas policy and Federal or State regulatory guidance. If needed, Equian will outreach directly with our providers to arrange for release of medical records.

Submission of Itemized Bills:

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 billed charges on the original claim, claim will be denied. All itemized charges must be billed with corresponding revenue codes. Itemized bills may be further subject to a 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 at \$25,000 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 will be reviewed.

If you have any questions on the review process, please reach out to your provider experience representative directly or by calling our toll-free phone number at **1-855-221-5656**.

In addition, Aetna Better Health has contracted with Conduent (CDR) and OptumInsight to conduct credit balance reviews.

OptumInsight and Conduent (CDR) has been assigned to identify and recover credit balance overpayments on our behalf at our contracted facilities. Both vendors will review accounts in a credit balance status where Aetna Better Health of Kansas made a primary or secondary payment. They will request access to a current credit balance report listing any credit balance account with Aetna Better Health of Kansas insurance or plan code listed as primary or secondary. This is strictly a review of patient accounting records and will not involve medical records. They will perform all work necessary to identify and process our credit balances, including printing any necessary backup documentation from your system and records as required. As an integral part of the process, you will be given an opportunity to review and approve of each refund prior to a recovery by us.

Claim Resubmission

Providers have 365 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim do **not** constitute reconsideration or claim dispute.

Providers may resubmit a claim for a variety of reasons including:

- Originally denied because of missing documentation, incorrect coding, etc.
- Incorrectly paid or denied because of processing errors
- Retroactive Eligibility

Note: Providers have 1 year (365 days) to resubmit a corrected claim.

Include the following information when filing a paper claim resubmission:

- Use the Resubmission Form located on our main website under “Forms”.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy) is acceptable.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address.

Providers can submit resubmissions electronically if no additional documentation is required. For electronic resubmissions, providers must submit a frequency code of seven or eight

Please note: Providers receive an EOB when we process their disputed claim. Providers may call our CICR department during regular office hours to speak with a representative about their claim dispute. The CICR department can verbally acknowledge receipt of the resubmission, reconsideration, and the claim dispute. Our staff can discuss, answer questions, and provide details about status. Providers can access the Availity Web Portal to submit claims through our clearing houses, check the status of a resubmitted/reprocessed or adjust a claim.

Remittance Advice

Aetna Better Health generates up to two checks weekly. Claims processed during a payment cycle appear on a remittance advice (“remit”) 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. Providers have access to view remittance advice through the Availity Web Portal as well.

We provide a separate remit for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.

- **Remit Date** represents the end of the payment cycle.
- **Beginning Balance** represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced (*i.e., this is the dollar amount located on the previous remittance's ending balance*).
- **Discount** is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- **Interest** is the total amount that is listed as interest paid to claims.
- **Refund Amount** is the amount refunded to ABH via check, from either a Provider or a pay-n-chase TPL payment. All claims within the Remittance Advice that have a "Refund Amount" listed within the individual claim line will have the grand total listed in the Header Box on page 1 of the Provider's Remittance Advice.
- **Amount Recouped** is the total dollar amount recovered by Aetna Better Health. (*i.e., the total of all "R" claims*).
- **Amount Paid** is the total amount paid on this remittance
- **Ending Balance** is the total amount, taking into account any refunds and/or recoupments. If there is an ending balance, it will become the beginning balance on the next remittance advice.
- **Payment #** is the unique EFT/Check # for the Remittance Advice. There are separate checks and remits for each line of business in which the provider participates.
- **The Line of Business** refers to the line of business applicable for this remit, and should reflect Aetna Better Health of Kansas-KanCare
- **Tax Identification Number (TIN)** refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Column 1:
 - Member Name
 - Account Number
 - Claim Provider
 - Refund Amount, if applicable
 - Adjustment of Claim #, if applicable
 - Column 2:
 - Member Number
 - Date Received
 - NPI#
 - Refund Reference #, if applicable
 - Column 3:
 - Claim#
 - Authorization #, if received
 - Billed DRG
 - Column 4
 - Claim Status
 - Place of Service
 - DRG
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim. For example:

Code/Description

CO - Contractual Obligations. Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.

OA - Other adjustments.

PI - Payor Initiated Reductions. Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer.

PR - Patient Responsibility.

- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information (see sample below).

We can provide an electronic version of the Remittance Advice. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through the claims processing system and receive payment for claim by EFT. You must also be able to receive ERA through an 835 file. We encourage our providers to take advantage of the claims processing system, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Experience department for assistance with this process.

Remit Sample on the next few pages:

**Sample Remit:
Front:**



Federal regulation prohibits billing Medicaid members, unless noted as member responsibility on this remittance advice. Page 3 of 9

Billing Provider Name: [REDACTED]
 TIN: [REDACTED]
 NPI: [REDACTED]
 Line of Business: Aetna Better Health of Kansas- KanCare

Remit Date:	12/08/2023
Beginning Balance:	0.00
Discount:	0.00
Interest:	0.00
Refund Amount:	0.00
Amount Recouped:	0.00
Amount Paid:	157.94
Ending Balance:	0.00
Payment #:	[REDACTED]

We have a new remit design. If you need assistance in understanding any of the information on this remittance advice, go to our website www.aetnabetterhealth.com and view the How to Read document. For other concerns please call the number on the back of the member's ID card. Prefer to use electronic transactions, contact your current EDI vendor, and request Aetna Better Health through Change Healthcare.

Member Name: [REDACTED]	Member #: [REDACTED]	Claim#: [REDACTED]	Claim Status: REVERSED
Acct #: [REDACTED]	Date Received: 20230610	Auth#: [REDACTED]	Place of Service: [REDACTED]
Claim Provider: [REDACTED]	NPI #: [REDACTED]	Billed DRG: [REDACTED]	DRG: [REDACTED]
Adjustment of Claim #: [REDACTED]			

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/CAP	Billed Amt.	Allowed Amt.	Not Payable Remark	Member Responsibility			Other Remark	Paid Amount	
										Ded PR1	Coins PR2	Copay PR3			
1	03/20/23	87801			-1	FFS	-136.61	-41.23	-95.38 CO45	0.00	0.00	0.00		-41.23	
2	03/20/23	87491 59			-1	FFS	-136.58	-41.22	-95.36 CO45	0.00	0.00	0.00		-41.22	
3	03/20/23	87591 59			-1	FFS	-136.58	-41.22	-95.36 CO45	0.00	0.00	0.00		-41.22	
4	03/20/23	87661 59			-1	FFS	-134.83	-40.69	-94.14 CO45	0.00	0.00	0.00		-40.69	
5	03/20/23	87798 59			-1	FFS	-136.63	-41.23	-95.40 CO45	0.00	0.00	0.00		-41.23	
6	03/20/23	87798 59			-2	FFS	-273.23	-82.46	-190.76 CO45	0.00	0.00	0.00		-82.46	
Payment # [REDACTED]							Claim Total:	-954.45	-288.05	-666.40	0.00	0.00	0.00	0.00	-288.05

Member Name: [REDACTED]	Member #: [REDACTED]	Claim#: [REDACTED]	Claim Status: DENIED
Acct #: [REDACTED]	Date Received: 20231202	Auth#: [REDACTED]	Place of Service: [REDACTED]
Claim Provider: [REDACTED]	NPI #: [REDACTED]	Billed DRG: [REDACTED]	DRG: [REDACTED]
Adjustment of Claim #: [REDACTED]			
Claim Level Messages: MA67			

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/CAP	Billed Amt.	Allowed Amt.	Not Payable Remark	Member Responsibility			Other Remark	Paid Amount
										Ded PR1	Coins PR2	Copay PR3		
1	03/20/23	87801			1	FFS	136.61	41.23	136.61 CO252	0.00	0.00	0.00		0.00
2	03/20/23	87491 59			1	FFS	136.58	41.22	136.58 CO252 N4 MA04	0.00	0.00	0.00		0.00
3	03/20/23	87591 59			1	FFS	136.58	41.22	136.58 CO252 N4 MA04	0.00	0.00	0.00		0.00
4	03/20/23	87661 59			1	FFS	134.83	40.69	134.83 CO252	0.00	0.00	0.00		0.00

If you have any questions please contact the Claims Inquiry and Claims Research (CICR) Department at 1-855-221-5656 or visit our website at www.aetnabetterhealth.com/kansas

Check History ID [REDACTED] Payment ID [REDACTED]

ENV 4553 5 OF 8 F

Sample Remit:

Back:

20210501

PL14022001

4 OF 8 B
ENV 4553

Messages

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

- 1) **Claims Inquiry:** please call 1-855-221-5656, Monday - Friday, 8:00 AM to 5:00PM CST to verify that your claim was processed correctly, or for clarification of information. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Experience Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.
- 2) **Revised Claims Resubmission and Reprocessing:** A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Better Health of Kansas from processing the claim. Health care providers must submit a corrected claim within 365 days from the claim date of service.

For Claims Resubmission: Mark at the top of the claim "resubmission" or "corrected claim" 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 Corrected Claim MUST be sent to:

Aetna Better Health of Kansas
P.O. Box 982961
El Paso, TX 79998

- 3) A copy of the Provider Manual which includes information on health plan policies and procedures, provider reconsideration appeal and grievance process, and important information, is available via the website www.aetnabetterhealth.com/kansas.
- 4) If you would like to report healthcare fraud related issues, please call the toll-free hotline at 1-800-338-6361 or contact us by email at aetnaai@aetna.com.

5) To return this check please mail within 60 days to:
Aetna Better Health of Kansas
Attention: Finance
P.O. Box 982979
El Paso, TX 79998-2979

Please mail a refund check for any overpayments or claim processing errors within 60 days to:
Aetna Better Health of Kansas
Attention: Finance
PO Box 841004
Dallas, TX 75284-1004

- 6) To sign up for Electronic Funds Transfer (EFT) payments or Electronic Remittance Advices (ERAs), please visit our website at www.aetnabetterhealth.com/kansas in order to complete the EFT/ERA enrollment form. Follow the instructions on the form for submission.

CHAPTER 18: APPEAL AND GRIEVANCE SYSTEM

[Back to Table of Contents](#)

Member Appeal and Grievance System Overview

Members or their designated representative can file an appeal or grievance with Aetna Better Health orally or in writing. A representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, other provider, or an attorney. Members must designate a representative in writing unless it is the treating or prescribing provider who may file an appeal on behalf of the member without written consent. **When representatives, including a provider, file on behalf of a member, we consider the cases a member appeal or grievance and is subject to the member appeal or grievance timeframes and policies.**

***Note - Although providers may be an authorized representative for a member in an appeal, they may not request continuation of benefits for a member.**

Members and their designated representatives, including providers, with written consent may also file:

- A State Fair Hearing
- A State Appeal Committee
- A Reconsideration through the KDHE-DHCF Secretary
- District Court Appeal
- A Grievance with the state

Aetna Better Health informs members and providers of the member appeal and grievance system processes for Aetna Better Health and State appeals and grievances. We include this information in the Member Handbook and in this Manual and is available on our website. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability at no cost to the member.

The treating or prescribing provider may also file an External Independent Third-Party Review (EITPR) on behalf of the member. EITPR appeals may only be filed by the provider for denials of a new healthcare services or a claim for reimbursement. An EITPR review will be at no cost to the member.

We prohibit any punitive action in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing an appeal or grievance with us or the KDHE.

Member Grievance Process

Standard Grievances

A grievance is an expression of dissatisfaction regarding any aspect of our policies, procedures, or services, or a provider care or service. This includes quality of care concerns. Members or their designated representative may file grievances with us orally or in writing at any time.

We respond to standard grievances within 30 calendar days. If we are unable to resolve a grievance within the specified timeframe, we may extend the grievance decision date by 14 calendar days. If we take an extension, we will only do it when the delay is in the member's best interest. If we take an extension, we will a) make reasonable efforts to give prompt oral notice of the delay, and b) within 2 calendar days we will give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. In these cases, we provide information describing the reason for the delay in writing to the member and, upon request, to KDHE within the original timeframe, and the grievance will be resolved within 44 calendar days from receipt. In addition, a member may request an extension. We automatically grant a member's request for extension.

Expedited Grievances

Aetna Better Health resolves all grievances effectively and efficiently. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where the member was denied expedited prior authorization or expedited appeal processing, or we took an extension on the decision-making timeframe for a prior authorization or on an appeal. A member or his/her authorized representative, including providers, may request an expedited grievance either orally or in writing. We resolve expedited grievances within 72 hours of receipt.

For expedited grievances, we make reasonable effort to provide oral notice of the grievance decision and follows the oral notice with written notification. We advise members in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision.

How to File a Member Grievance

Grievances may be filed by calling Member Services at **1-855-221-5656** or for the hearing-impaired **Relay 711**, or they may be submitted in writing via fax to: **1-833-857-7050** or postal mail to:

Aetna Better Health of Kansas
Attn: Appeals and Grievance Department
PO Box -81040
5801 Postal Road
Cleveland, OH 44181
Fax: **1-833-857-7050**
Email: KSAppealandGrievance@AETNA.com

Member Appeal Process

Standard Appeals

Appeals are a formal request for Aetna Better Health to reconsider an adverse benefit determination. Members or their designated representative can file a standard appeal with us orally or in writing within 60 calendar days plus an additional 3 calendar days for mailing time from the date of the notice of adverse benefit determination.

If we take an extension, we will a) make reasonable efforts to give prompt oral notice of the delay, and b) within 2 calendar days we will give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision

The Notice of Adverse Benefit Determination informs the member of the following:

- Our decision and the reasons for our decision
- A clear explanation of further appeal rights and the time frame for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to a State Fair Hearing
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them at any time during the appeal process
- Their right to request an expedited resolution and the process for doing so
- The policies or procedures which provide the basis for the decision
- Members may request that their benefits continue through the appeal process, when all of the following criteria are met:
 - The member, their authorized representative or provider on behalf of the member files the appeal within 60 calendar days (3 additional calendar days is allowed for mailing time) of the date of the notice of adverse benefit determination. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment .
 - An authorized provider ordered the services.
 - The original period covered by the initial authorization has not expired.
 - The member requests extension of benefits within 10 calendar days of the postmarked notice of adverse benefit determination or prior to the effective date the notice of adverse benefit determination as sent.
 - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- The health plan will continue the member's benefits until one of the following occurs:
 - The member withdraws the appeal or requests a State Fair Hearing.
 - Ten (10) calendar days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
 - The time period or service limits of a previously authorized service has been met.
 - The member or member's authorized representative requests previously authorized waiver services or benefits to end and be replaced with another waiver service or benefit.

Appeals may be filed either verbally by contacting the Member Services department or by submitting a request in writing. We may request a written, signed appeal following your oral appeal. We will process your oral appeal even if we don't receive your written, signed appeal.

We respond to standard appeals within 30 calendar days. If we are unable to resolve an appeal within the specified timeframe, we may extend the appeal decision date by 14 calendar days. If we take an extension, it can only be done when the delay is in the member's best interest. In these cases, we provide information describing the reason for the delay in writing to the member and, upon request, to KDHE within the original timeframe, and the appeal will be resolved within 44 calendar days from receipt. In addition, a member may request an extension. We automatically grant a member's request for extension.

We advise all parties to the appeal in writing of the outcome of the investigation of the appeal. The Appeal Decision letter includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells a member how to obtain information on filing a State Fair Hearing.

Expedited Appeal

Aetna Better Health resolves all appeals as quickly as the member's health condition requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where the member's provider or we determine that the standard appeal timeframes could seriously harm the member's health. A member or their authorized representative, including providers, may request an expedited appeal either orally or in writing. We resolve expedited appeals within 72 hours of receipt.

We do not require written confirmation of the member's written consent for a provider to act on the member's behalf. We resolve expedited appeals within 72 hours of receipt. If we determine that waiting the standard timeframe will not harm the member's health, the member's appeal will be transferred to a standard appeal and will be decided within the normal 30 calendar day timeframe. We attempt to call the member to advise that we are following the standard timeframes and we follow up with written notification within 2 calendar days with this information. The notification includes information that the member may file a grievance if he/she is dissatisfied with the denial of expedited processing time of his/her appeal.

If we are unable to resolve an expedited appeal within the specified timeframe, we may extend the appeal decision date by 14 calendar days. If we take an extension, it can only be done when the delay is in the member's best interest. In these cases, we provide information describing the reason for the delay in writing to the member and, upon request, to KDHE within the original timeframe, and the appeal will be resolved within 72 hours plus 14 calendar days from receipt. In addition, a member may request an extension. We automatically grant a member's request for extension.

Post-service items or services are not eligible for expedited processing.

How to File Member an Appeal

Appeals may be filed by calling Member Services at **1-855-221-5656** or for the hearing-impaired **Relay 711**, or they may be submitted in writing via fax to: **1-833-857-7050** or postal mail to:

Aetna Better Health of Kansas
Attn: Appeals and Grievance Department
PO Box -81040
5801 Postal Road
Cleveland, OH 44181
Fax: **1-833-857-7050**
Email: KSAppealandGrievance@AETNA.com

State Fair Hearing

Members or their designated representative, including a provider acting on their behalf with written consent, may request a State Fair Hearing through KDHE after the appeal with us within 120 calendar days (plus an additional 3 calendar days is allowed for mailing), from the date of the appeal resolution letter. The Appeal resolution Letter includes information on how to submit a State Fair Hearing appeal.

The request for a State Fair Hearing must be submitted in writing to the following:

State of Kansas
Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327

Members may request their benefits continue through the State Fair Hearing process when all of the following criteria are met:

- The member or provider acting on behalf of the member files the state fair hearing request within 120 calendar days (3 calendar days is allowed for mailing time) of the date of the appeal resolution letter. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services.
- The original period covered by the initial authorization has not expired.
- The member requests extension of benefits within 10 calendar days of the notice of appeal resolution letter being sent.

The health plan will continue the member's benefits until one of the following occurs:

- The member withdraws the request for State Fair Hearing.
- Ten (10) calendar days pass after the State Fair Hearing officer mails the notice, providing the resolution of the State Fair Hearing against the member.
- A State fair hearing officer issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.
- The member or member's authorized representative requests previously authorized waiver services or benefits to end and be replaced with another waiver service or benefit.

The Office of Administrative Hearings renders the final decision about services. If the decision agrees with our previous decision, and the member **continued to receive services**, the member may be responsible for cost of services received during the State Fair Hearing. If the State Fair Hearing decision favors the member, then we approve the services immediately. If the member's services were continued while the appeal was pending, we provide reimbursement for those services within 72 hours according to the terms of the final decision rendered by the Office of Administrative Hearings State Fair Hearing Appeals Division.

Additional External Appeals

Following State Fair Hearing, members or their designated representative may have the following additional appeal rights. Each subsequent appeal right is described with the process to file in each resolution letter:

- A State Appeal Committee
- A Reconsideration through the KDHE-DHCF Secretary
- District Court

The treating or prescribing provider may also file an External Independent Third-Party Review (EITPR) on behalf of the member. EITPR appeals may only be filed by the provider for denials of a new healthcare services or a claim for reimbursement. An EITPR review will be at no cost to the member.

Provider Appeal and Grievance System Overview

Providers may file an appeal or grievance verbally or in writing. A provider, acting on behalf of a member with the member's written consent, may file a grievance or appeal with us.

When a provider files on behalf of a member, we consider the cases a member appeal or grievance and is subject to the member appeal or grievance timeframes and policies.

*Note- Although providers may be an authorized representative for a member in an appeal, they may not request continuation of benefits for a member.

We prohibit punitive action in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing an appeal or grievance.

Provider Grievances

Both network and out-of-network providers may file a grievance verbally or in writing directly with us in regard to our policies, procedures, or any aspect of our administrative functions including dissatisfaction with the resolution of a disputed claim within 180 calendar days from the incident being grieved. Providers can also file a verbal grievance with us by calling **1-855-221-5656**. Providers can submit written grievances to:

**Aetna Better Health of Kansas
Attn: Appeals and Grievance Department
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181**

Fax: **1-833-857-7050**

We acknowledge provider grievances in writing within 10 calendar days of receipt. We respond to standard provider grievances within 30 calendar days. If the grievance requires research or input by another department, the Appeal and Grievance department will engage the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and our written policies and procedures, collecting pertinent facts from all parties. Providers are not required but may present the grievance, with all research, to the Grievance Committee for decision. No individual reviewers or members of the Grievance Committee will have been involved in any prior decision making related to the grievance. When the grievance includes a clinical issue, a provider with the same or similar specialty will participate and render the final resolution.

Provider Reconsiderations

A provider may request a claim reconsideration if they would like us to review the claim decision. Claim reconsideration is available to providers prior to submitting an appeal. Reconsideration requests must be submitted within 120 calendar days (an additional 3 calendar days is allowed for mailing time) from the date of the notice of the claim denial.

Providers may submit reconsideration requests orally by contacting the Provider Experience department at **1-855-221-5656** or for the hearing-impaired **Relay 711**. Providers can submit a written reconsideration to:

Aetna Better Health of Kansas
Attn: Reconsideration
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: **1-833-857-7050**
Email: KSAppealandGrievance@AETNA.com

We acknowledge provider reconsiderations in writing within 10 calendar days of receipt. Aetna Better Health will review your reconsideration request and provide a written response within 30 calendar days of receipt.

Provider Appeals

A provider may file an appeal in writing if they are not satisfied with the outcome of the reconsideration determination or if they wish to bypass the reconsideration process. A provider may file an appeal within 60 calendar days (an additional 3 calendar days is allowed for mailing time) of the date of the notice of adverse action if no reconsideration was requested. If reconsideration was requested, providers have 60 calendar days (an additional 3 calendar days for mailing time) from the date of the reconsideration resolution letter to file an appeal. Post service items or services are standard appeal and are not eligible for expedited processing.

Appeals should be sent to the following:

Aetna Better Health of Kansas
Attn: Appeals
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: 1-833-857-7050

We acknowledge provider appeals in writing within 10 calendar days of receipt. Aetna Better Health responds to standard provider appeals within 30 calendar days. If the appeal requires research or input by another department, the Appeal and Grievance department will engage the affected department and will coordinate with the affected department to thoroughly research each appeal using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties. The appeal, with all research, may be presented to the Appeal Committee for decision. No individual reviewers or members of the Appeal Committee will have been involved in any prior decision making related to the appeal. When the appeal includes a clinical issue, a provider with the same or similar specialty will participate and render the final decision.

External Independent Third-Party Review (EITPR)

Providers may request an EITPR for denials of a new healthcare services or a claim for reimbursement following a provider appeal through Aetna Better Health after the appeal with Aetna Better Health. This request must be completed within 60 calendar days (an additional 3 calendar days for mailing time), file following the date of the appeal resolution letter. Information on how to submit an EITPR request is included in Appeal Resolution Letter. It is not required to request an EITPR before requesting a State Fair Hearing. The provider may go direct to State Fair Hearing. An EITPR review will be at no cost to the member.

- The request must be sent using the **Request for External Independent Third-Party Review Form** found at <https://www.aetnabetterhealth.com/kansas/providers/resources/forms>
- By Signing this form, providers acknowledge they will be held responsible for the costs associated with the EITPR, in the event the reviewer upholds the Aetna Better Health of Kansas determination. Forms that are not signed will not be processed.
- The request must identify the specific issue or dispute in question and why Aetna Better Health's decision is incorrect.
- The request must also include the provider's designated contact's information such as name, mailing address, phone, fax and email.
- The request should be in writing and sent to:

Aetna Better Health of Kansas
Appeal and Grievance Department
PO Box 81040
5801 Postal Road

Cleveland, OH 44181

ax: **1-833-857-7050**

Email: KSAppealandGrievance@AETNA.com

We acknowledge the EITPR in writing within 5 business days to the provider's designated contact, notify Kansas Department of Health & Environment, Division of Health Care Finance (KDHE-DHCF) of the provider's request, and notify the affected member of the provider's request for review. In the event Aetna appeals the review we acknowledge we will within 15 business days of receipt of the approved review request, the MCO will provide all documentation submitted by the provider for the MCO's appeal process to KDHE-DHCF or notify KDHE-DHCF that the provider has not completed the appeal process. The provider can have someone they know; a friend, relative, spokesperson, or attorney represent them or act on their behalf. A provider must tell Aetna Better Health in writing, the name of that person and how they can reach him or her.

The external reviewer will render a decision within 30 calendar days of receiving the information and will notify provider, Aetna and KDHE within 10 business days of receiving the reviewer's decision. If the EITPR decision reverses the decision to deny Aetna Better Health will authorize or provide the disputed payment promptly. If the final result of the EITPR is to uphold the Aetna Better Health decision, the provider can request a State Fair Hearing within 30 calendar days plus 3 calendar days from the date of the MCOs EITPR decision letter.

Provider State Fair Hearing

Providers may request a State Fair Hearing through the Office of Administrative Hearings after the appeal with Aetna Better Health. This request must be completed within 120 calendar days (an additional 3 calendar days for mailing time), file following the date of the appeal resolution letter. Information on how to submit a State Fair Hearing request is included in Appeal Resolution Letter.

Providers may request a State Fair Hearing for a denial of payment for covered services. Providers may also request a State Fair Hearing regarding an incorrect payment by Aetna Better Health or a notice from Aetna Better Health regarding an overpayment.

The request for a State Fair Hearing must be submitted in writing to the following:

State of Kansas
Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327

Additional External Appeals

Following a State Fair Hearing, providers or their designated representative may have the following appeal rights. Each subsequent appeal rights are described with the process to file in each resolution letter:

- A State Appeal Committee
- A Reconsideration through the KDHE-DHCF Secretary
- District Court

Oversight of the Appeal and Grievance Processes

The Appeal and Grievance Manager manages the Appeal and Grievance processes and reports to the Director of Appeal and Grievance with a dotted line to the Chief Operating Officer. This includes:

- Documenting individual appeals and grievances
- Coordinating resolutions
- Maintaining the data for all appeals and grievances in the Appeal and Grievance Application
- Tracking and reviewing grievance and appeal data for trends in quality of care or other service-related issues
- Reporting all data to the Service Improvement Committee and Quality Management Oversight Committee

We integrate Aetna Better Health's grievance and appeals processes into our quality improvement program. Our Quality Management (QM) department's grievance system processes include:

- Review of individual quality of care grievances
- Aggregation and analysis of grievance and appeal trend data
- Use of data for quality improvement activities including collaboration with credentialing and recredentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

Through these QM department processes, individuals with the authority to take corrective action are actively engaged in the appeal and grievance process. We routinely review data received through member and provider appeals and grievances to identify opportunities for improvement and to apply continuous quality improvement principles.

CHAPTER 19: FRAUD, WASTE, AND ABUSE

[Back to Table of Contents](#)

Fraud, Waste and Abuse

Aetna Better Health has an aggressive, proactive fraud, waste, and abuse program that comply with state and federal regulations. Our program targets areas of health care related fraud and abuse including internal fraud, electronic data processing fraud, and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to appropriate state and federal agencies as mandated by Kansas State Administrative Code. During the investigation process, we maintain the confidentiality of the member, or people referring the potential fraud and abuse case.

We use a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and members share the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit

Our SIU conducts proactive monitoring to detect potential fraud, waste, and abuse, and is responsible to investigate cases of alleged fraud, waste, and abuse in all markets. The SIU is comprised of experienced, full-time investigators, analysts, a full-time dedicated information technology organization, and supporting management and administrative staff.

Providers who may have questions, seeking information, or want to report potential fraud, waste, or abuse are encouraged to contact the SIU via the toll-free fraud hotline at **1-800-275-7704**.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate to conduct in-depth analyses of case-related data.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Kansas Hotline at 1-866-275-7704
Note: We keep your identity confidential.

You can also report provider fraud to the following:

- Office of Inspector General in the Attorney General's office at **785-296-8637** or through their online form at: <https://ag.ks.gov/complaint-center/medicaid-fraud-abuse>
- Medicaid Fraud Control Unit (MFCU) of the Attorney General's office, at **1-866-551-6328** or <https://ag.ks.gov/fraud-abuse/medicaid-fraud>
- Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477)** or <https://oig.hhs.gov/fraud/report-fraud/index.asp>

The MFCU is a division of the Office of Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for services funded by Medicaid.

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy – verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Take action if you identify a problem
- Remember you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Fraud, Waste, and Abuse Defined

- **Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste:** over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse:** provider practices inconsistent with sound fiscal, business, or medical practices resulting in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet

professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of fraud, waste, and abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services never rendered
- Billing for services at a higher rate than is justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health due to improper payments to providers or overpayments
- Physical or sexual abuse of members**

Fraud, waste, and abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members a cash payment to encourage enrollment in a specific plan
- Selecting or denying members based on their illness profiles or other discriminating factors
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Billing for services not rendered or supplies not provided includes billing for appointments the members fail to keep another example is a "multi patient" in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the members
- Double billing (billing both Aetna Better Health and another)
- Misrepresenting the date services were rendered or the identity of the member who received the services
- Misrepresenting who rendered the service or billing for a covered service other than the non-covered service that was rendered

Fraud, waste, and abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death**
- Falsely billed procedures create an erroneous record of the member's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction

**Note: Providers must report all adverse incidents involving individuals receiving services by agencies licensed or funded by KDADS online through the Adverse Incident Report (AIR) web application, which is located in the KDADS web applications, within 24 hours of becoming aware of the incident.

- AIR (adverse incident reporting system): <https://www.kdads.ks.gov/provider-home/providers/adverse-incident-reporting>

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another member's ID)
- Forging and altering prescriptions
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.)

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. **Written Standards of Conduct:** Development and distribution of written policies and procedures that promote commitment to compliance and address specific areas of potential fraud, waste, and abuse.
2. **Designation of a Compliance Officer:** Designation of an individual and a committee responsible for and with authority for operating and monitoring the compliance program.
3. **Effective Compliance Training:** Development and implementation of a regular, effective education and training program.
4. **Internal Monitoring and Auditing:** Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas.
5. **Disciplinary Mechanisms:** Policies to consistently enforce standards and addresses dealing with individuals or entities excluded from participating in the Medicaid program.
6. **Effective Lines of Communication:** Between the Compliance Officer and employees, managers, directors, and members of the compliance committee, as well as related entities.

- a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality.
 - b. Related entities must report compliance concerns and suspected or actual misconduct.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant Laws

Providers contracted with Aetna Better Health must agree to be bound by and comply with all applicable state and federal laws and regulations.

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

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & 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
- 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.
- Red Flag Rule (Identity Theft Protection)
 - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
- Health Insurance Portability and Accountability Act (HIPAA) requires:
 - Transaction standards

- Minimum security requirements
 - Minimum privacy protections for protected health information
 - National Provider Identification (NPI) numbers
- 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.
- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health providers will follow federal and state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal healthcare programs, including programs for children and families accessing Aetna Better Health services through the state of Kansas.
- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program prohibits identified entities and providers excluded by the OIG or GSA from conducting business or receiving payment from any federal healthcare program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
 - Automatic disbarment
 - Prison time

Exclusion Lists & Death Master File

We check the Office of Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS, or System of Award Management (SAM)), the Social Security Death Master File (DMF), and any other such databases as the state may prescribe. KDHE also performs monthly screenings of all KMAP enrolled providers. Screenings include licenses, OIG, SAM,

Medicare Exclusion database (TIBCO), DMF, and Drug Enforcement Agency (DEA) database.

Aetna Better Health does not participate with or enter into any provider agreement with any individual or entity excluded from participation in federal healthcare programs, who has a relationship with excluded providers, or who has been terminated from Medicaid or any programs by the state for fraud, waste, or abuse. The provider must agree to assist Aetna Better Health as necessary in meeting our obligations under the contract with the state to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of healthcare services.

CHAPTER 20: MEMBER ABUSE AND NEGLECT

[Back to Table of Contents](#)

Mandated Reporters

As mandated by Kansas Administrative Code and Kansas Revised Statutes, all providers who work with or have any contact with an Aetna Better Health member are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation, and any other form of maltreatment of a member to the appropriate state agency.

Children

Providers must report suspected or known child abuse and neglect to the Kansas Department for Children and Families (DCF) or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: healthcare professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

If the child is in immediate danger, call **911** as well as the following, as applicable:

- Kansas Protection and Report Center at **1-800-922-5330**

Vulnerable Adults

Providers must immediately report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult to one of the following State agencies:

- Children & Adults: Abuse, Neglect, and Exploitation of an Adult or Child must be reported to the Kansas Protection Report Center at **1-800-922-5330**
- The National Domestic Violence Hotline at **1-800-799-SAFE (7233)**
- The local county Police or Sheriff’s Department

For members age 60 or older, providers may report verbally or in writing to the:

- Elder Abuse must be reported to the Kansas Department of Children and Families Adult Protective Services at **1-800-922-5330**
- Nursing Homes, Hospitals, Home Health Agency Abuse and Neglect: Report abuse to the Kansas Department of Aging and Disability Services at **1-800-842-0078**

Providers must report all adverse incidents involving individuals receiving services by agencies licensed or funded by KDADS online through the Adverse Incident Report (AIR) web application, which is located in the KDADS web applications, within 24 hours of becoming aware of the incident.

- AIR (adverse incident reporting system):
 - <https://kdads.ks.gov/kdads-commissions/survey-certification-and-credentialing-commission/adverse-incident-reporting-air-system>
 - <https://kdads.ks.gov> and select “Adverse Reporting System (AIR)” under the Quick Links section on the right-hand side of the page.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine or imprisonment up to six months.

Reporting Identifying Information

Any provider who suspects that a member may need protective services should contact the appropriate state agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers, if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

Provider Experience staff notified of suspected abuse or neglect must alert Aetna Better Health Director/Manager/Supervisor immediately. Aetna Better Health managers will take appropriate action and notify the health plan Compliance Officer who will determine if further action is necessary.

Our providers must fully cooperate with the investigating agency and make related information, records, and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to Determine Abuse or Neglect

When a state agency or an Aetna Better Health Service Coordinator becomes aware of a potential case of neglect or abuse of a member, we work with the agency and the PCP to help the member receive a timely physical examination for determination of abuse or neglect. In addition, we notify the appropriate regulatory agency of the report.

Depending on the situation, our Service Coordinators provide the member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, Behaviors, and Signs

Abuse

Examples of Abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (bed sores)

- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior Indicators of a Child Wary of Adult Contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Behaviors of Abusers (Caregiver or Family Member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect:

- The intentional withholding of necessities and care
- Not providing necessities and care because of lack of experience, information, or ability

Signs of Neglect:

- Malnutrition or dehydration
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities such as washing, dressing, and bodily functions

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

Reference:

- https://statelaws.findlaw.com/kansas-law/kansas-child-abuse-laws.htmlhttp://kslegislatureorg/li_2014/b2013_14/statute/039_000_0000_chapter/039_014_0000_article/039_014_0030_section/039_015_0030_k/http://22www.dcf.ks.gov/services/PPS/Pages/ReportAdultAbuseNeglect.aspx
- <https://www.dcf.ks.gov/services/Pages/default.aspx>
- <https://kdads.ks.gov/provider-home/providers/adverse-incident-reporting>