



Aetna Better Health[®] of Kentucky
2020 Provider Manual

Updated: **March 2020**



Important phone numbers (Quick Reference Guide)

Department	Phone Number
Member Services	1-855-300-5528 (TTY users dial 711 /TDD users dial 1-800-627-4702)
Behavioral Health Crisis Hotline	1-888-604-6106 (TDD: 1-866-200-3269 , TTY: 711)
Network Relations	1-855-454-0061
Prior Authorization	<p>Medical: Phone 1-888-725-4969 Fax 1-855-454-5579</p> <p>Behavioral Health: Phone 1-855-300-5528 Fax 1-888-604-6106</p> <p>Pharmacy: CoverMyMeds Phone 1-866-452-5017 SureScripts Phone 1-866-797-3239 or 1-866-797-3239 Fax 1-855-799-2550</p>
Claims Inquiry Claims Research (CICR)	1-855-300-5528
Dental (Avesis)	1-855-214-6776
Vision (Avesis)	1-855-214-6776
Radiology (eviCore)	1-888-693-3211
Pharmacy (CVS)	1-855-300-5528
Pain Management (eviCore)	1-888-584-8742
Fraud & Abuse	1-855-300-5528
Office Location	Aetna Better Health of Kentucky 9900 Corporate Campus Drive, Suite 1000 Louisville, KY 40223
Claims Information	EDI Payor ID (Claim) #128KY PO Box 65195 Phoenix, AZ 85082-5195
Member Eligibility Verification at KYHealthChoices.net	https://public.kymmis.com
Case and Disease Management Referrals	1-888-470-0550
Returned Checks and Refunds	Aetna Better Health of Kentucky Attn: Finance P. O. Box 842605 Dallas, TX 75284-2605
Complaints Appeals Address	Aetna Better Health of Kentucky Fax 1-855-454-5585 Attn: Appeals Department PO Box 81040 5801 Postal Rd Cleveland, OH 44181
Website	https://www.aetnabetterhealth.com/kentucky
Provider Portal	https://www.aetnabetterhealth.com/kentucky



WELCOME

Welcome to Aetna Better Health® of Kentucky. We are pleased that you are part of our network of providers. We are committed to providing accessible, high quality service to our members in Kentucky, and we greatly appreciate our providers' efforts in helping us achieve that goal.

Dear Providers,

Thank you for being a valued member of our provider network. Because of your partnership and commitment Aetna Better Health of Kentucky's members receive the best possible care, and we cannot thank you enough for that. Together, we serve more than 217,000 Kentuckians, and your patients are at the forefront of everything we do.

Within this manual, you will find information and direction to resources that we hope you will find helpful. We constantly strive to provide an optimal provider experience for every provider in our network. Please do not hesitate to reach out to our provider experience team if we can ever assist you.

Our leadership team, comprised of many lifelong Kentuckians, looks forward to continuing our partnership with you. Thank you again for all that you do.

Best Regards,

A handwritten signature in black ink that reads "Jonathan Copley". The signature is written in a cursive, flowing style.

Jon Copley, CEO



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Department for Medicaid Services

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

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

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

About Us

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

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

Service Area in Kentucky

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



Our Values

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



NCQA Accredited

Aetna Better Health is one of the largest managed care health plans in Kentucky. Our commitment to the highest standards has earned us an accreditation status of Commendable by the National Committee for Quality Assurance (NCQA) for 2018–2019.



Model of Care

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

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

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

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

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

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

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

About this Manual

This provider manual serves as a guide to the policies and procedures governing the administration of Aetna Better Health and is an extension of and supplement to the Provider Agreement between Aetna Better Health of Kentucky and the contract practitioners and providers delivering health care services to our members. Throughout the provider manual, you will find answers to common questions you may have regarding Aetna Better Health of Kentucky. We retain the right to add to, delete and otherwise modify this manual. Revisions will be binding and will comply with all statutory, regulatory, contractual, and accreditation requirements. As changes occur, we will continue to supply our providers with updates via letters, emails, provider website, newsletters, and through your Network Relations Team.

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 email comments, feedback, and suggestions directly to the Network Relations team at KYProviderRelations@aetna.com.



Provider Experience

Our approach to working with providers is based on our **Aetna Better Together** philosophy. Provider engagement and collaboration is a cornerstone of our processes and critical to achieving improved provider experience. Our highly trained and experienced Provider Services leadership and staff have a combined 172 years of experience working for Kentucky Providers.

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

We pledge to:

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

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

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

Providers can access their Network Managers contact information on the Aetna Better Health website using this link.

<https://www.aetnabetterhealth.com/kentucky/providers/>

Provider can also access previous provider communication, newsletters, and updates at the Aetna Better Health website using this link. <https://www.aetnabetterhealth.com/kentucky/providers/news>

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

Provider Orientation

Upon credentialing approval by Aetna Better Health, a Network Manager will reach out via telephone or email to welcome new providers to the network. This communication will include a welcome letter for new contracts, copy of the contract, link to the provider manual, and the scheduling of new provider orientation.

We conduct new provider orientations both conducted on-site and via webinars. As part of the orientation, providers are given information on a variety of topics including the following:

The provider orientation will cover the following topics and much more:

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

Site Review

Network Managers conduct site visits with hospitals, primary care physicians, and specialists annually. Our staff will visit the provider location to ensure that all contractual requirements are being met. Provider Experience leadership conduct follow up surveys via email to ensure that the visit covered all the provider's needs.

On-site Meeting

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

Confidentiality

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

Provider Identifiers

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

Responsibilities of the Primary Care Provider

Our primary care provider (PCP) serves as the cornerstone of our Aetna Better Health provider network. You play a vital role in ensuring that each of our members have a medical home and access to necessary health care, which provides continuity and coordination of care. Aetna Better Health PCPs include:

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

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

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at <https://public.kymmis.com>. Please contact Aetna Better Health Customer Service at **1-855-300-5528** if assistance is needed.
- Verify member's status as a Lock-In member and determine the providers to which a member is restricted for services.
- Promote access to quality care by using participating Aetna Better Health specialists, hospitals, and ancillary providers.
- Make referrals for specialty care and other medically necessary services to participating providers and obtain prior authorization from Aetna Better Health before using out of network providers, when necessary.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Contact Aetna Better Health for those services that require authorization prior to the services being performed.
- Coordinate with Aetna Better Health case and disease management staff in developing care plans for members enrolled in care management.
- Conduct behavioral health screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or substance use problems.
- Exchange information between behavioral healthcare and primary care practitioners, medical/surgical specialists, organizational provider, or other relevant medical delivery systems.
- Approve appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings.
- Appropriate utilization of psychopharmacological medications and adherence to consistent guidelines for prescribing by behavioral and medical practitioners.
- Screening and managing of patients with coexisting medical and behavioral conditions.
- When a member changes PCP, the medical records or copies of medical records shall be forwarded to the new PCP or partnership within ten (10) days from receipt of request. The PCPs shall have members sign a release of medical records before a medical record transfer occurs.

Responsibilities of the Specialist and Consulting Practitioners

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

Responsibilities of the Hospital Provider

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

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at <https://public.kymmis.com>. Please contact Aetna Better Health Customer Service at **1-855-300-5528** if assistance is needed.
- Verify member's status as a Lock-In member and determine the providers to which a member is restricted for services.
- Conduct behavioral health screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or substance use problems.
- Exchange information between behavioral healthcare and primary care practitioners, medical/surgical specialists, organizational provider, or other relevant medical delivery systems.
- For members presenting to the hospital Emergency Department (ED) with a non-emergency condition, determine if the member is enrolled in the Lock-In program. **As required by Kentucky Medicaid regulations, Aetna Better Health does not cover non-emergency services provided to Lock-In members if provided by a hospital other than the member's Lock-In hospital.**
- Obtain prior authorization for services in accordance with the Prior Authorization List
- Participate in concurrent review process and discharge planning process.
- Promote access to quality care by directing members to use Aetna Better Health network providers, with the approval of member's PCP or directing provider.
- Coordinate with the member's PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Provide all of the health care services and supplies that are medically necessary, that are generally available by the provider, and which the provider is licensed to provide to members and that are covered under the terms of the applicable benefit plan.
- Provide covered services in accordance with the terms of their applicable Participating Provider Agreement and the bylaws, rules, regulations, policies and procedures of the provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the same time of service.
- Submit Emergency Department medical records to the member's PCP.
- Submit documentation including, but not limited to, medical records, itemized bills, and invoices to support the authorization and billing of services, as requested.
- Participating providers may not discriminate against Aetna Better Health members by providing treatment differently from other persons receiving services.

Responsibilities of the Ancillary Provider

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

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at [www.https://public.kymmis.com](https://public.kymmis.com). Please contact Aetna Better Health Customer Service at **1-855-300-5528**, if assistance is needed.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Promote access to quality care by directing members to use Aetna Better Health network providers.

- Coordinate with the member’s PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Maintain a comprehensive and legible medical record and make such records available upon request.
- Provide all of the health care services and supplies that are medically necessary, that are generally available by the provider, and which the provider is licensed to provide to members and that are covered under the terms of the applicable benefit plan.
- Provide covered services in accordance with the terms of their applicable participating provider agreement and the bylaws, rules, regulations, policies and procedures of provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the time of service.
- Participating providers may not discriminate against Kentucky Medicaid managed care members by providing treatment differently from other persons receiving services.

Responsibilities of Behavioral Health Care Providers

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealthNet at [www.https://public.kymmis.com](https://public.kymmis.com). Please contact Aetna Better Health Customer Service at **1-855-300-5528**, if assistance is needed.
- Obtain prior authorization for services in accordance with the Prior Authorization List.
- Promote access to quality care by directing members to use Aetna Better Health network providers.
- Coordinate with the member’s PCP the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Provide all of the health care services and supplies that are medically necessary, that are generally available by the provider, and which the provider is licensed to provide to members and that are covered under the terms of the applicable benefit plan.
- Provide covered services in accordance with the terms of their applicable participating provider agreement and the bylaws, rules, regulations, policies, and procedures of provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the time of service.
- Participating providers may not discriminate against Kentucky Medicaid managed care members by providing treatment differently from other persons receiving services.
- Communication between behavioral health care providers and the member’s PCP helps to ensure members receive coordination of care. The sharing of clinical information promotes quality health care and a comprehensive treatment plan to assess for coexisting medical conditions, medication interactions, or other medical concerns.
- Refer members with known or suspected and untreated physical health problems or disorders to such member’s PCP for examination and treatment, with the member’s or the member’s legal guardian’s written consent.
- Initial and quarterly (or more frequently if clinically indicated) summary reports of a member’s behavioral health status to the member’s PCP, with the member’s or the member’s legal guardian’s consent.

Cultural Competency

Aetna’s approach to meet the linguistic and cultural needs of our members includes the development of a comprehensive cultural competency program. Cultural competency and health literacy are at the core of our service delivery. Aetna’s health care equity director prepares a detailed Cultural Competency Plan (CCP) annually to ensure engagement of all health plan leaders and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards and to ensure compliance. The CCP outlines the processes used to develop and maintain a culturally

competent staff and provider network. This comprehensive plan includes strategies designed to assist our staff, providers, and subcontractors with integrating cultural and linguistic competence and health literacy into every aspect of our organization. Our CCP focuses on effective and equitable care and services by respecting and honoring each enrollee's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background.

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

- Cultural competency and impacts on health care
- Provider obligations for delivering culturally competent care
- Tools and resources such as Aunt Bertha, an online repository of community services
- Social determinants of health and trauma-informed care
- Training staff on the need to understand and respect cultural differences and develop services that better meet the needs of minority populations and remove barriers to care
- Assisting members with limited English proficiency
- Providing access to interpretive and American Sign Language services for Aetna enrollees

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

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

The Aetna Better Health 24-Hour Nurse Line employs bilingual staff, supplemented as needed, by a third-party interpretation service vendor. The nurse line also supports members needing TDD/TTY services via a local TTY access number.

Please refer to **important phone numbers** at the beginning of this manual.

Health Plan Website

The health plan website is a resource for members and providers. Providers will find information such as the member handbook, provider manual, and the formulary on the health plan website.

Providers can use the website to:

- Access the provider manual
- Access the formulary
- Access Clinical Guidelines
- Locate plan resources and frequently used documents
- Register for and access the provider portal
- Access the Secure Provider Portal
- Access the online Provider Directory

Visit the Website: <https://www.aetnabetterhealth.com/kentucky/>

Provider Inquiries

Aetna Better Health uses an Interactive Voice Response system (IVR) to allow providers to self-serve anytime. You can access the IVR by calling the Customer Service Department at **1-855-454-0061**. You can speak with a customer service representative between the hours of 7 a.m. and 7 p.m., Monday through Friday. From the IVR you can simply speak your responses to be routed to the correct area.

- Caller Type – ***Press star (*) to indicate Provider***
- Claims – Press 1
 - Check Status – Press 1
 - Submit – Press 2
 - Something Else – Press 3
- Eligibility/Benefits – Press 2
 - Medical – Press 1
 - Vision – Press 2
 - Dental – Press 3
 - Mental Health – Press 4
 - Something Else – Press 5
- Authorizations – Press 3
 - Submit One – Press 1
 - Concurrent Review – Press 2
 - Retro Review – Press 3
 - Peer-to-Peer Review – Press 4
 - Fax Authorization Request – Press 5
- More Options – Press 4
 - Report Fraud and Abuse – Press 1
 - Pharmacy Help Desk – Press 2
 - Care Manager – Press 3
 - Provider Services – Press 4
 - Something Else – Press 5

Secure Provider Portal

The Secure Provider Portal is a web-based platform which connects providers with real-time member information anytime. With a secure log on, providers can perform many functions within the web-based platform. The following information can be obtained from the Secure Provider Portal:

- [Member Eligibility Search](#) – Verify current eligibility status, copayment, and benefit information.
- [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, claims number, or service dates. Only claims associated with the user's account provider ID will be displayed.

- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account provider ID will be displayed.
- Authorization Submission – Submit an authorization request on-line. Three types of authorization types are available:
 - Medical Inpatient
 - Outpatient
 - Durable Medical Equipment – Rental
- Real Time Authorization Tool – Search any CPT/HCPC to see if there is a prior authorization requirement.
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member’s compliance with any of the HEDIS measures.
- Secure Messages – Send and receive secure messaging.

For additional information regarding the Secure Provider Portal, please access the Secure Provider Portal instructions located on our website. If you’re interested in using this Secure Provider Portal, please complete the portal registration form. (www.aetnabetterhealth.com/kentucky/providers/portal)

Provider Experience regularly hosts education webinars on how to use the Provider Portal. Please visit our website for dates or to sign up!

Changes in Provider and Demographic Information

Providers are required to provide a 90-day prior written notice to both Aetna Better Health of Kentucky ‘s Provider Network Management Department and DMS of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions/deletions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.

Changes may be reported by completing the “Demographic Update/Change Form” which is located on the Aetna Better Health of Kentucky website, under Provider Tab then Document Library. The form must be returned to the Provider Experience Team via email at KyProviderRelations@Aetna.com.

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

Aetna Provider Partnership Program (AP³)

Aetna Better Health has implemented a new Aetna **Provider Partnership Program (AP³)**. AP³ is a combination of Councils, Concepts, and Campaigns. The councils are external and internal work groups. These work groups bring concepts to light, which result in administrative burden reduction campaigns.

AP³ reviews, monitors, and assesses the Aetna Better Health of Kentucky’s policies, practices, and potential innovations relative to provider partnerships with an emphasis on reducing administrative burden and implementing efficiencies, primarily for the benefit of the provider network.

Three external workgroups comprised of provider representatives and one internal workgroup comprised of health plan staff make up AP³. The purpose of the external workgroups is to provide a forum for provider groups and their office staff to highlight areas of administrative burden when working with Aetna Better Health of Kentucky and suggest synergies that would make their practices more efficient as it relates to the findings. The Internal workgroup consists of representatives from all health plan departments that interact with providers either directly or tangentially.

External Workgroups

- Practice Management Advisory Council (PMAC)
 - PMAC consists of provider and office staff representatives from PCP and Specialists Groups. The PMAC workgroup will be driven by Aetna Better Health of Kentucky network relationship managers.
- Ancillary Provider Management Advisory Council (APMAC)
 - APMAC consists of provider and office staff representatives from the following provider types:
 - Durable Medical Equipment
 - Chiropractor
 - Home Health
 - Laboratory/Toxicology
 - Medical Supplies
 - Skilled Nursing Facilities
- Behavioral Health Management Advisory Council (BHMAC)
 - BHMAC consists of provider and office staff representatives from the following provider types:
 - Community Mental Health Centers
 - Behavioral Health Service Organizations
 - Psychiatric Residential Treatment Facilities

Each work group will be encouraged to identify areas of administrative burden and suggest ways in which this administrative burden could be reduced. Providers that are selected and agree to join the AP3 will set on the council for a minimum of one year. If you are interested in any of the three councils, please contact Provider Experience to receive a selection form.

Joining our Network

All practitioners must have an effective Kentucky Medicaid ID in order to participate with Aetna Better Health of Kentucky.

New practitioners joining the network to become participating must first complete a contracting packet. You can find the Nomination form on the Aetna Better Health of Kentucky website <https://www.aetnabetterhealth.com/kentucky>. The Nomination form must be completed and emailed to KYProviderRelations@aetna.com. Someone from your Provider Experience team will work with you to complete the contracting packet.

During the contracting process practitioners will completed either a Provider Information Form or Group Roster, this will be submitted with your Disclosure of Ownership Form and W-9 along with the contract packet.

Credentialing/Re-Credentialing

Initial credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, including those joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the credentialing committee.

New practitioners joining the network to become participating must first complete a contracting packet. You can find the Nomination form on the Aetna Better Health of Kentucky website. The Nomination form must be completed and emailed to KYProviderRelations@aetna.com. During the contracting process practitioners will complete either a Provider Information Form or Group Roster, which will be submitted with your Disclosure of Ownership Form, W-9, and the contract packet.

For practitioners who are joining a participating group, the Provider Information Form or Group Roster along with the Disclosure of Ownership and your W-9 must be submitted directly to the health plan. You can submit this directly to your Network Manager/Network Relationship Manager or to the KYProviderRelations@Aetna.com mailbox.

Credentialing Process and Application Requirement for Kentucky Medicaid

For practitioners we use Council for Affordable Quality Healthcare (CAQH) DataSource for our applications. 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 of the health plans and hospitals participating in the CAQH effort.

- Form KAPER-1/CAQH credentialing application shall be used when credentialing or re-credentialing health care professionals in a managed care plan. In addition to the Form KAPER-1/CAQH credentialing application, our applicant must provide the following information:
 - Copy of current valid license to practice
 - Copy of current DEA certification (if applicable)
 - Copy of educational degrees
 - Copy of board certificate (if applicable)
 - Copy of board certificate to serve children with special needs under 21 years of age (as applicable)
 - Copy of current malpractice coverage certificate
 - Copy of current BNDD certification (if applicable)
 - Copy of completed IRS W-9 form
 - Signed Attestation and Consent for Release of Information/Release from Liability form, including current date
 - Disclosure of Ownership form
 - Copy of physician collaborative practice agreement (if applicable)
 - Signed Kentucky MAP—811 form (for new practitioners for Medicaid ONLY)
 - A statement from the applicant regarding:
 - The ability to perform the essential functions of the positions, with or without accommodation
 - Lack of present illegal drug use
 - History of loss of license and felony convictions
 - History of loss or limitation of privileges or disciplinary activity
 - Sanctions, suspensions or terminations imposed by Medicare or Medicaid
 - Applicant's attestation to the correctness and completeness of the application

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

Re-Credentialing Requirements

Aetna Better Health re-credentials each participating provider at least every 36 months. Our providers are required to submit updated information for re-credentialing. Failure to provide the requested information could result in termination from our network.

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

Provider Selection Standards

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

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

Aetna Better Health and our providers are partners in managing the health care of our members. Because of this mutual responsibility, we require our providers to adhere to the following standards:

- Providers shall offer covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services, supplies, and/or equipment.
- Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws. Additionally, providers must maintain member records in an accurate and timely manner and according to the Medical Record Documentation Standards included in this Provider Manual.

- Providers will not deny, limit, or condition the furnishing of covered health care services to members based on health factors including, but not limited to, mental or physical illness, claims experience, medical history, genetic information, and evidence of insurability or disability.
- Providers shall cooperate with Aetna Better Health medical management activities and procedures to identify, assess, and establish a treatment plan for members with complex or serious medical conditions. This includes returning phone calls, answering correspondence, and responding to Aetna Better Health staff, as needed, so they can perform their medical management duties.
- Providers must obtain authorizations for all hospitalizations and other services specified in this Provider Manual as requiring prior authorization.
- Providers must agree to the terms of the Aetna Better Health provider participation agreement, including but not limited to, all state and federal required provisions and maintain an acceptable professional image in the community.
- Providers must keep their licenses and certifications current and in good standing and cooperate with the Aetna Better Health re-credentialing program. Aetna Better Health must be notified of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health.
- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/re-credentialing process. Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide at least 15 days' notice prior to the cancellation, loss, termination, or transfer of coverage.
- Providers look solely to Aetna Better Health for payment of services furnished to members, and must not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have claim or recourse against a member, or anyone acting on behalf of a member, under any circumstances unless explicitly approved for reason of coordination of benefits or subrogation. Applicable cost sharing can be collected at the time of service or billed to the member. Services cannot be denied to any member with cost sharing responsibilities if he/she is unable to pay at the time the service is rendered. The member may be billed for the cost share amount.
- Providers shall ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health, including medical records data required, and ensure the information is submitted on the appropriate claim form.
- In the event the provider or Aetna Better Health seeks to terminate the participating provider agreement, it must be done in accordance with the contract.
- Providers must submit demographic or payment data changes at least 60 days prior to the effective date of change.
- Providers must be enrolled in Kentucky Medicaid, must have an active Kentucky Medicaid ID number, and must maintain enrollment in Kentucky Medicaid.
- Providers shall be available to Aetna Better Health members as outlined under "Scheduling Appointments and Waiting Times." Providers will arrange with other Aetna Better Health participating providers to deliver 24-hour on-call coverage for their members, as outlined within this Provider Manual. Please note, National Committee for Quality Assurance (NCQA) requires that access is no less to Medicaid recipients than it is for all other patients.
- Providers shall ensure timely and confidential transfer of records between providers as outlined in Quality Management of this Provider Manual under "Transfer of Medical Records." Providers must become familiar, and to the extent necessary, comply with Aetna Better Health "Members Rights and Responsibilities" in Member Services and Benefits of this Provider Manual.

- Providers will ensure they honor all Aetna Better Health members’ rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.
- By entering into the participating provider agreement, provider agrees to comply with all enumerated terms and conditions, abide by all applicable Aetna Better Health policies, procedures, and programs, and the Aetna Better Health Provider Manual. Further, provider agrees to Aetna Better Health’s ongoing monitoring of the provider to ensure compliance with the foregoing. The following is a representative list of the policies, procedures, and programs with which providers must comply. This list is not exhaustive and is subject to change upon appropriate notice to the affected providers.
 - Quality Improvement programs including, but not limited to, poly-pharmacy program, provider efficiency monitoring, data collection, and reporting programs, such as HEDIS® (Healthcare Effectiveness Data and Information Set)
 - “Never Event”/provider-preventable conditions policy
 - Fraud and Abuse/Program Integrity programs
 - Utilization management/review programs, including, but not limited to, full cooperation with the appeals and grievances process as may be requested
- Participating providers agree to comply with the quality improvement, utilization review, peer review, grievance, credentialing and re-credentialing programs, and any other policies and procedures that Aetna Better Health may implement, including amendments made to the above-mentioned policies, procedures, and programs from time to time.
- In the event a provider fails to meet any of the participation requirements stated herein or does not agree to comply with such requirements going forward, Aetna Better Health reserves the right to refuse participation to a provider applicant. In addition, once providers are accepted into the network, they must continue to meet all such requirements or be subject to termination with cause in accordance with their participating provider agreement. In all cases where termination is proposed, Aetna Better Health will act in accordance with the timeframes and notice requirements stated in the applicable provider contract.
- Note: The poly-pharmacy program requires review of prescription practices including, but not limited to, members with a high number of unique drugs prescribed, drug duplication, interactions, and missing medications.
- Aetna Better Health encourages providers to contact their Network Relations Manager at any time if they require further details on requirements for participation.

Provider Terminations

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

Provider Termination with Aetna Better Health of Kentucky

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

Provider Termination by Aetna Better Health of Kentucky

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

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

Member Notification of Provider Terminations

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

Continuation of Care after Termination

Unless a provider is terminated from Aetna Better Health's network due to fraud or quality of care issues, the provider shall continue to treat members who are receiving treatment at the time of termination or who are hospitalized on the date the participating provider agreement terminates or expires until the course of treatment is completed or through the date of each such member's discharge from an inpatient facility, whichever is longer. In the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is at least twelve weeks and one day pregnant at the time of termination. Continuation of services shall be made in accordance with the terms and conditions of the provider's participation agreement with Aetna Better Health as it may be amended and in effect at the time, including but not limited to the compensation rates and terms set forth therein. Provision for the continuation of care shall guarantee that the member is not liable to the terminating provider for any amounts owed for medical care other than deductibles or cost sharing specified in the member's benefit plan.

Other Provider Concerns

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

members of their right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

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

Kentucky Health Information Exchange - KHIE

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

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

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

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

For additional information on KHIE, please visit <https://khie.ky.gov/nr/Pages/resources.aspx>.

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



Medical Services

Aetna Better Health has a network of contracted providers including hospitals, ancillaries, physicians, and advanced practice nurses available to cover all medically necessary services required by members. Please refer to the Provider Search option on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a complete listing of network providers.

Member Identification (ID) Card

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

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

- [www.https://public.kymmis.com](https://public.kymmis.com)
- Aetna Better Health of Kentucky Member Services at **1-855-300-5528**
- Our portal at <https://www.aetnabetterhealth.com/kentucky>

Additionally, a provider is required to verify if a member has been enrolled in the Lock-In Program which directs members to certain providers. Failure to verify a member's enrollment in the Lock-In Program will result in claims denials for providers who are not on the member's restricted provider list.

To confirm the Aetna Better Health member's PCP selection, call Aetna Better Health Member Services at **1-855-300-5528**.

Sample Member ID Card

<p>AETNA BETTER HEALTH® OF KENTUCKY </p> <p>Name Last Name, First Name Date of Birth 00/00/0000 Member ID/State Medicaid ID# 0000000000 Sex X</p> <p>PCP Last Name, First Name PCP Phone 000-000-0000 Effective Date 00/00/0000</p> <p>----- RxBIN: 610591 RxPCN: ADV RxGRP: RX8831 CVS/caremark For pharmacist use only: 1-855-319-6290</p> <p>www.aetnabetterhealth.com/kentucky</p> <p><small>THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEKYMED1</small></p>	<p>In case of an emergency go to the nearest emergency room or call 911.</p> <p>IMPORTANT NUMBERS FOR MEMBERS</p> <p>Member Services 1-855-300-5528 (TTY users 711, TDD users 1-800-627-4702)</p> <p>Behavioral Health 1-888-604-6106 24 Hour Nurse Line 1-855-620-3924</p> <p>IMPORTANT NUMBERS FOR PROVIDERS</p> <p>Eligibility 1-855-300-5528 Authorization 1-888-725-4969</p> <p>Submit claims to PO Box 65195, Phoenix, AZ 85082-5195 Payer ID 128KY <small>KYMED1</small></p>
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Member Services Department

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

We will be closed on these federal holidays:

- New Year’s Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Member Secure Portal

At <https://www.aetnabetterhealth.com/kentucky>, members can register for their own secure member portal accounts. However, we’ve customized the member portal to better meet their needs. Members will have access to:

- Health and Wellness Appraisal – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- Educational resources and programs – Members can access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status – Members can follow a claim from the beginning to the end, including current stage in the process, amount approved, amount paid, member cost (if applicable), and the date paid.
- Pharmacy benefit services – Members can find out if they have any financial responsibility for a drug, learn how to request an exception for a non-covered drug, and find an in-network pharmacy by zip code. They can also review drug interactions, side effects, and risk for medications or determine the generic substitute for a drug.
- Personalized health plan services information – Members can now request a member ID card, change PCPs, and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain information regarding referrals and authorization requirements. In addition, they can find benefit and financial responsibility information for a specific service.
- Innovative services information – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- Health information Line – The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.

- Wellness and prevention information – We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self- management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at <https://www.aetnabetterhealth.com/kentucky> or call Member Services at **1-855-300-5528**.

Members’ Rights and Responsibilities

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

Member Rights:

- To get good medical care regardless of race, color, religion, sex, age, disability, sexual orientation, gender identity, or nationality.
- To be treated with respect and dignity and to have their privacy protected.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To have a choice about their Aetna Better Health of Kentucky primary care provider and be able to change their PCP within the rules.
- To get medical care when they need it.
- To ask questions and get complete information about their medical condition and treatment options, including specialty care, regardless of cost or benefit coverage.
- To be told that services are not covered before they get them.
- To be part of all decisions about their health care including the right to refuse treatment.
- To ask for a second opinion.
- To have their medical records and care kept private.
- To look at copies of their medical records, get copies if they want them, and to get assistance with them in accordance with applicable federal and state laws.
- To file a complaint, an appeal, or ask for a state fair hearing from the contractor and or the Department for Medicaid Services if they have problems with their eligibility or health care.
- To receive help with filing a complaint or appeal.
- To have timely access to care including specialty care.
- To make sure communication or physical barriers do not limit timely access to care.
- To get information in a way that is easy to understand.
- To get free translation services, if needed.
- To prepare Advance Medical Directives according to Kentucky laws.
- To ask for a description of payment methods Aetna Better Health of Kentucky uses to pay providers for member care.
- To be told at least 30 days before any program or site changes that affects them.
- To make recommendations regarding the organization’s member rights and responsibilities policy.
- To receive information about the organization, its services, its practitioners, and providers and members’ rights and responsibilities.
- Any Indian enrolled with Aetna Better Health is eligible to receive services from an Aetna Better Health network participating Indian Health Services, Tribally operated facility/program, and Urban Indian Clinic (ITU) provider or

an ITU primary care provider. (Any Indian enrolled with the Contractor eligible to receive services from a participating ITU provider or an ITU primary care provider shall be allowed to receive services from that provider if part of Contractor’s network.)

Member Responsibility:

- To give the best information they can so that Aetna Better Health of Kentucky and their providers can take care of them and their family.
- To follow their PCP’s instructions and care plans, actively participating in their personal healthcare decisions and practicing healthy lifestyles.
- To call their PCP first when they need medical care, except in an emergency. Call **911** or go to the closest emergency room.
- To learn the difference between emergencies and urgent care.
- To go to providers who take their Aetna Better Health of Kentucky member ID card.
- To show their Aetna Better Health of Kentucky ID card every time they get medical services.
- If they have other health insurance coverage (including Medicare), to show their other insurance card every time they get medical services
- To keep all appointments and be on time or calling to cancel an appointment if they cannot get there.
- To follow Aetna Better Health of Kentucky and Kentucky Medicaid policies and procedures.
- To follow the rules of their PCP’s office or clinic. If they or others do not follow the rules, their provider can ask them to leave.
- To ask their PCP questions if they do not understand something about their medical care.
- To tell the truth about themselves and their medical problems.
- To report suspected fraud and abuse.
- To tell the Department for Community Based Services (DCBS) or Social Security Association (SSA) about changes to their name address and/or telephone number OR a birth, death, marriage and/or other insurance.
- To understand their rights and responsibilities as a Kentucky Medicaid member.

Member Incentives

Aetna Better Health is offering a member incentive program to encourage consistent improvements in health outcomes for our members.

Promise Reward Program	<p>Members can earn a Promise Rewards special gift after their baby is born. They will earn a free diaper bag which includes common baby items and a \$10 gift card if they complete the following:</p> <ul style="list-style-type: none"> • Complete the post-partum visit. This visit must be within 7 to 84 days after the baby is born. • The obstetrical provider will need to complete the Promise Rewards form and return it to Aetna Better Health of Kentucky.
Cribs for Moms Program	<p>Aetna Better Health offers a portable crib incentive for pregnant members at 37 weeks of pregnancy. You must visit your doctor within 42 days of enrolling with our plan and participate in a maternity care management program.</p> <ul style="list-style-type: none"> • The obstetrical provider will need to complete the Cribs for Mom form and return it to Aetna Better Health of Kentucky.

Aetna Better Choices to Health Incentive Program	<p>Members can earn gift cards after they complete the following checkups:</p> <ul style="list-style-type: none"> • \$10 gift card for completing a Lead Screening test for children prior to their 2nd birthday • \$10 gift card for completing a diabetic retinal eye exam for adults 18 to 75 years old • \$10 gift card for completing spirometry testing for members 40 years or older with COPD • \$20 gift card for completing a follow-up visit with a mental health practitioner within seven (7) days of discharge after a hospitalization for mental illness (6 years of age or older). <p>Proper coding on claims will be evaluated prior to the member receiving a gift card. Please ensure the coding is related as identified in the HEDIS® measure. You may contact Aetna Better Health of Kentucky for proper billable codes.</p>
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Bonus Benefits Offered to Aetna Better Health Members

We are pleased to offer our members the following extra benefits.

• Adult vision benefit – receive a free pair of eyeglasses
• New member Health Risk Assessment gift card program with Walmart
• Back to School Assistance Program
• No limits on Over-the-Counter (OTC) medications with doctor prescription
• Free slow cooker nutrition course
• Free Vending Machine access for the homeless
• Free text message and email notification program
• Free baby showers for expecting mothers
• Free KidsHealth program with online access to interactive resources
• Free flu shots, hepatitis A vaccines, and other immunizations
• Free Sports Physicals for school aged children
• Free well adult and well child visit, annually
• Free eyeglasses for children
• Free wellness portal with healthy recipes, wellness support, and interactive tutorials
• Free second chance support services and resources, including job fairs and employment opportunities

Member Selection of a PCP

For some members, selecting a PCP can be an overwhelming experience, as there are many factors to consider, such as gender, language, and location. In addition, some members may not understand why they must choose a PCP. A PCP understands a member’s medical history, family medical history, and personal habits. PCPs can also tailor solutions that are specific to a member’s health. Aetna provides up-to-date information to help members make an informed choice

based on their needs by offering a wide variety of PCPs who are located throughout the Commonwealth, including federally qualified health centers (FQHCs), rural health centers, individual practitioners, and large group providers that offer multiple service locations.

Members are given the opportunity to select primary care providers (PCPs) when they enroll in the Medicaid Managed Care program. Members may select a specialty provider to serve as PCP under certain circumstances depending on the member's needs including for a member who has a gynecological or obstetrical health care need, disability or chronic illness. These requests will be reviewed by the Aetna Better Health Medical Director to ensure the requested specialist agrees to accept the role of PCP and assume all the responsibilities associated with this role.

If a member does NOT select a PCP within 30 days from enrollment, Aetna Better Health assigns one. Aetna Better Health shall consider factors such as language, location, and special needs.

The member may request a PCP change if the provider was automatically assigned by Aetna Better Health upon notification of the PCP assignment. A list of PCPs is made available to all members. Member Services representatives are available to assist members with PCP selection.

Members are given the freedom to select participating PCPs based on age limit restrictions. Members are encouraged to choose a PCP that is geographically convenient but are not restricted by any geographic locations.

Procedure for Members to Change PCP

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

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

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

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

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

Member Disenrollment from PCP

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

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

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

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

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

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

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

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

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

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

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

Member Disenrollment from Aetna Better Health of Kentucky

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

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

Member Copayments

Aetna Better Health may require copays for members for certain services. A copayment (or copay) is the amount a member must pay for a covered service. Please refer to the Benefit Schedules for the full list of specific copays amounts for members. Below is a list of the copays for 2019.

Service or Item	Copayment Amount
Preferred and non-preferred generic drug	\$1
Preferred brand name drug that does not have a generic equivalent	\$1
Non-preferred brand name drug	\$4
Chiropractor	\$3
Dental	\$3
Podiatry	\$3
Optometry	\$3
General ophthalmological services	\$3
Office visit for care by a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife, or any behavioral health professional	\$3
Physician service	\$3
Visit to a rural health clinic, primary care center, or federally qualified health center	\$3
Outpatient hospital service	\$4
Emergency room visit for a non-emergency service	\$8
All Inpatient hospital admission	\$50
Physical therapy, speech therapy, occupational therapy	\$3
Durable medical equipment	\$4
Ambulatory surgical center	\$4
Laboratory, diagnostic, or x-ray service	\$3

Benefit Determinations

Aetna Better Health has established benefit plans for its members. Please refer to <https://www.aetnabetterhealth.com/kentucky> for the most current version of the applicable benefits plans.

For specific questions or for clarification of covered benefits, contact the Aetna Better Health Member Services Department at 1-855-300-5528.

Member Appeals and Grievances

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

Member Complaints

Members have two (2) processes to indicate dissatisfaction. Members may file an appeal or a complaint. If a member or the member's representative asks, we can expedite the processing time of the appeal. We will grant the request to speed up the appeal if the normal 30-day timeframe could seriously harm the member's life or health or ability to attain, maintain, or regain maximum function. The grievance process does not have an option to request expedited processing.

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

Process Definitions		
Process	Definition	Determination timeframes
Grievance (complaint)	A member complaint is any expression of dissatisfaction about us or the way we operate. Concerns about actions we took based on our contract with CHFS aren't included in this definition.	Member grievance will be resolved within 30 calendar days.
Appeal	A member appeal is a request for a review of any matter about an action which is defined as a denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part of payment for a service; or our failure to act within acceptable timeframes for prior authorization review process. If we determine the request for an expedited appeal does not meet the Commonwealth's definition of an expedited appeal, we'll process the appeal in the standard appeal period. We'll make reasonable effort to contact the member by phone promptly if we can't process the appeal as an expedited appeal. We'll also send a letter to the member, letting them know we will process the appeal as a standard appeal. If the member files an appeal by phone, they must also send us	Member appeal will be resolved within 30 calendar days; such timeframe may be extended with the member's consent or at the member's request, when in the member's best interest, by no more than 14 calendar days.

Process Definitions		
Process	Definition	Determination timeframes
	an appeal letter in writing to complete the appeal request. Without the appeal letter, we're unable to open the case.	

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

In some cases, we may extend the complaint response time by 14 days if it's beneficial to you. If this is not acceptable to you, you have the right to file a grievance to dispute the extra days.

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

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

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

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

Provider Filing on Behalf of Member

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

Facility Site Review

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

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

Providers who don't have an acceptable facility site review may be required to provide a corrective action plan.

Member Appeals

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

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

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

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

Access to Records

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

Title VI and VII & Translator and Interpreter Services

Aetna Better Health is committed to serving all our members. If you need assistance with translator or interpreter services, either from us or from your provider, we have programs in place to make sure you get the care you need. Please call us at **1-855-300-5528** (TTY users dial **711**/TDD users dial **1-800-627-4702**).

Title VI of the Civil Rights Act of 1964

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

Title VII of the Civil Rights Act of 1964

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

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

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

Steps providers must take to comply:

- Designate a Civil Rights Coordinator or contact person for your facility.
- Public notification of a non-discrimination policy.
- Display a “Non-Discrimination in the Provision of Services” poster in a location easily accessible and visible to clients.
- Conduct civil rights training for employees.
- Develop a particular complaint procedure for clients wanting to file a complaint of discrimination.
- Collect and maintain information regarding racial/ethnic makeup of workforce (if over 50 employees) and information on client or service complaints.

(Source: <https://peu.momed.com/momed/presentation/providerenrollmentgui/CivilRightsFormsWindow.jsp>)

Availability Standards

The following access and availability standards must be provided by all our participating providers:

Medical services	
Appointment type	Access/appointment standard
Emergent	Immediately
Urgent care appointments	Within 48 hours
Non-urgent sick appointments	Within 72 hours
Initial new member appointment	Less than 12 weeks
Routine and preventative care	Within 30 days
Maternity care	
Appointment type	Access/appointment standard
Initial prenatal visit for newly enrolled pregnant women in first trimester	Within 14 days
Initial prenatal visit for newly enrolled pregnant women in second trimester	Within 7 days
Initial prenatal visit for newly enrolled pregnant women in third trimester	Within 3 days
Initial prenatal visit for newly enrolled pregnant women with high risk pregnancies	Within 3 days
Behavioral health & substance use services	
Appointment type	Access/Appointment Standard
Emergent	Within 6 hours for non-life-threatening emergency services
Urgent care	Within 48 hours
New member appointments	Within 10 days
Aftercare appointments	Within 7 days after hospital discharge
Other referrals	Within 60 days
Routine and preventative care	Within 10 days

Waiting Times

The average waiting time for appointments should not exceed 45 minutes from scheduled appointment time. This includes time spent in the lobby and the examination room prior to being seen by a provider. Appointment logbooks or sign-in sheets must be maintained by providers to demonstrate compliance with this requirement.

(Exception: Waiting times may be longer when the provider works in urgent care appointments, a serious problem is identified, or the member has an unknown need or condition that requires more services or education than was described at the time the appointment was made).

Missed Appointments/Follow-up Visits

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

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

For additional information regarding transportation benefits, please reference transportation services under member services and benefits.

Twenty-four (24) Hour Access to Care

Providers are required to ensure access to care is provided 24 hours a day, 7 days a week. Providers are required to arrange and maintain after-hours on-call coverage with participating providers. This involvement ensures the overall quality and continuity of care for the member.

Network Relations randomly selects and surveys providers after their normal business hours to monitor compliance. Providers who do not meet the criteria for after-hours access will be contacted by Network Relations. Continued non-compliance will result in formal corrective action.

Management of After-Hours Access to Services

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

Authorizations of After-Hours Services

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

- **Covering providers**
Providers may use a back-up provider for on-call coverage in order to provide services 24 hours a day, 7 days a week. The coordination of on-call coverage is the sole responsibility of the arranging provider. Providers should use other Aetna Better Health participating providers for back-up coverage arrangements and ensure they are knowledgeable or have access to and will comply with Aetna Better Health policies and requirements. The provider remains ultimately responsible for the member's care.
- **Phone line transfer**
The provider's phone line is transferred directly to provider's designated after-hours number (i.e., mobile number or answering service). Aetna Better Health's participating providers are expected to respond to after-hours calls within 30 minutes of call received.

Member to Practitioner Ratio: PCP Capacity Monitoring

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

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

PCP Panel Limit

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

Panel Closings

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

Subcontracting Services

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

Medical Record Documentation

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

- Member name/member identification information on each page.
- Personal/biographical data, including date of birth, age, gender, marital status, race, or ethnicity, mailing address, email address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no telephone number exists, then provide contact name and number of emergency contacts), consent forms, identify language spoken, and guardianship information.
- Legible record to someone other than the author. Any record judged illegible by one reviewer shall be evaluated by another reviewer.
- All entries and encounters dated (month, day, and year) for the date of data entry and date of encounter.
- Provider identification by name of author and credentials (MD, DO, RN, MA, etc.).
- Medication allergies, adverse reactions, and any known allergies shall be noted in a prominent location and is kept up to date.
- Past medical history, including, but not limited to, serious accidents, operations, illnesses, prenatal/obstetrical history; for children: past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e., documentation of chickenpox).
- History and physical with appropriate documented subjective (chief complaints or purpose of visit) findings and should include the history of current illness. Appropriate objective findings (physical exam) are documented and related to complaints or purpose of visit.
- A diagnosis, working diagnosis, or medical impression must be documented related to the findings.

- Plan of action/treatment documented that is consistent with the diagnosis/impression and includes consultations, therapies, and prescribed regimens.
- Identification of current problems, significant illnesses, and medical conditions should be documented on the problem list. If the member has no known medical illnesses or conditions, the chart must include a flow sheet for preventive health care.
- The medication list records past and current medications, including dosages and date of initial or refill prescription, should be reviewed with each patient encounter and include the provider's initials and date indicating review of the medication list.
- Unresolved problems from previous office visits should be addressed in subsequent visits.
- When a member is treated at an emergency department, there should be a note acknowledging the visit (and the follow-up care, if indicated).
- Medical record should have a notation concerning follow-up care, call or return visit. Time to return should be noted in days, weeks, months or as needed (PRN).
- When a consultation is requested there should be a note or report from the consultant in the record that contains the ordering/covering physician's initials and date indicating review.
- Labs, X-rays, imaging reports, and other referrals for ancillary services that have been requested should have reports or results filed in the medical record that contain the ordering provider's initials or other documentation indicating review. Consults, abnormal labs, and imaging results have an explicit notation in the record of follow-up plans.
- Hospital discharge summaries are included as part of the medical record for all hospitalizations that occur while the member is under the primary care provider's care.
- Documentation of preventive health services including, but not limited to, record of immunizations and age appropriate screenings.
- Documentation of advance directives, whether executed or not, for all members 18 years and older.
- Pediatric records (members under twenty-one (21) years of age) should have a complete immunization record or notation regarding immunization status.
- Documentation of screening and counseling on tobacco use, alcohol use, substance use, and sexual activity for members 11 years of age and older.
- Documentation of screening and counseling on nutrition, diet, and exercise, including height, weight, and body mass index (BMI) for adults. Height, weight, and documentation of BMI percentile or BMI percentile plotted on an age-growth chart for children ages 3–17 years.
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the member resides or the Department for Public Health.
- Documentation of appropriate referral to consultants when applicable and evidence of correspondence from ancillary providers/facilities to primary care practitioners. This would include hospital discharge summaries, discharge summaries from emergency room visits, home health follow-up, nursing home/skilled nursing facility follow-up, and discharge information from free-standing surgical centers.
- All written denials of service and the reason for the denial.
- If any covered service provided by a provider requires completion of a specific form (i.e., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate state or federal regulations. Provider shall retain the form in the event of an audit and a copy shall be submitted to the Cabinet or Aetna Better Health, upon request.

Utilization Management

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

Program Oversight

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

Utilization Management Staff

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

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

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

Appropriate Utilization of Care without Conflict of Interest nor Incentives

We don't reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities for not authorizing health care services. No individual is compensated or provided incentives to encourage denials, limited authorization or discontinuation of medically necessary covered services. Aetna Better Health does not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood or on the perceived likelihood that the practitioner or staff member supports, or tends to support, denial of benefits. Individuals shall not participate in the review and evaluation of a case in which he/she has been professionally involved or where his/her judgment might be compromised. Utilization decisions are made based only on appropriateness of care and service and existence of coverage.

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

The following processes are in place in order to ensure appropriate utilization of health care:

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

Prior Authorization, Concurrent Review and Retrospective Review Criteria

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

To support prior authorization, concurrent review, and retrospective review decisions, we use nationally recognized evidence-based criteria with input from health care providers in active clinical practice. We apply these criteria based on medical necessity and appropriateness of the requested service, the individual member's circumstances, and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and as nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners in developing, adopting, or reviewing criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting practitioners/providers, when appropriate.

Prior Authorization

The prior authorization process supports:

- Verification of current member eligibility based on the information available from the Commonwealth via KYHealthNet at [www.https://public.kymmis.com](https://public.kymmis.com).
- The review of the service requested based upon the available benefit plan for the member.
- The evaluation of medical necessity of services based on the type of service, level of care and network availability as mandated by the Aetna Better Health contract with the Commonwealth of Kentucky.
- Accurate claims adjudication.
- Identification of members that may benefit from a referral to integrated care management.

Required Information

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

- Member name
- Ordering provider
- Aetna Better Health and/or Kentucky Medicaid number
- Date of birth
- Expected date of service
- Diagnosis
- Service requested
- Significant medical information related to the diagnosis and service requested
- Name of provider/facility rendering service

Prior Authorization List

For a comprehensive listing of authorization requirements by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes, please visit the Aetna Better Health provider portal at <https://www.aetnabetterhealth.com/kentucky> and refer to the prior authorization tool/directory.

If you do not have access to the portal, please contact Network Relations Team to register for portal access. The authorization requirements are updated periodically. Please utilize the provider portal to ensure you have the most up-to-date requirements.

Services Requiring Authorization

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided. For a comprehensive and current listing of authorization requirements, please refer to the provider portal at <https://www.aetnabetterhealth.com/kentucky>. If a provider performs a service that is medically necessary, that has already been prior authorized, the provider can submit the authorization request within 7 days of the service being performed. When submitting a request, all pertinent clinical information must accompany the request. Requests received or authorization change requests beyond 7 days post service will be denied for timely notification.

Requesting Authorization

Medical Providers may request authorization and submit notification Monday - Friday between the hours of 8 a.m. – 6 p.m. ET. The form is available on the website.

Behavioral Health Providers may request authorization and submit notification 24 hours a day/7 days a week. The form is available on the website: <https://www.aetnabetterhealth.com/kentucky/providers/library>

Fax the request form to:

- Medical: **1-855-454-5579**
- Outpatient Behavioral Health: **1-855-301-1564**
- Behavioral Health Psychological and Neuropsychological Testing: **1-844-885-0699**
- Call us toll free:
Medical: **1-888-725-4969**
Behavioral Health: **1-855-300-5528**
- Submit through our 24/7 Secure Provider Portal: <http://aetnabetterhealth-kentucky.aetna.com/>

Aetna's secure web-based provider portal offers access to the provider portal through secure single sign-on functionality that allows providers to submit, update and confirm authorization request any time.

InterQual

We use InterQual to ensure consistency in utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The InterQual guidelines are updated regularly.

For prior authorization of elective inpatient and outpatient physical health medical services, Aetna Better Health of Kentucky uses the following medical review criteria consulted in the order listed. If InterQual guidelines state "current

role remains uncertain” for the requested service, the next criteria in the hierarchy should be consulted and utilized (this also applies to concurrent review and non-elective conditions):

- Criteria required by applicable state or federal regulatory agency
- Pharmacy clinical guidelines, when applicable
- Applicable InterQual guidelines as the primary decision support for most medical diagnoses and conditions
- Nationally recognized standards
- Aetna Clinical Policy Council Review

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

- Criteria required by applicable state or federal regulatory agency
- InterQual guidelines, except for substance use services, will use American Society of Addiction Medicine (ASAM) criteria
- Level of Care Utilization System (LOCUS) – behavioral health services for adults
- Children and Adolescent Service Intensity Instrument (CASII) – behavioral health services for children and adolescents or Child and Adolescent Needs Strengths Scale (CANS)
- Early Childhood Service Intensity Instrument (ECSII) for young children
- Nationally recognized standards
- Aetna Clinical Policy Council Review

Prior Authorization, concurrent review, and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above.

Medical and behavioral health management criteria and practice guidelines are disseminated to all affected practitioners/providers, members, and potential members upon request by contacting Aetna Better Health’s Member Services at **1-855-300-5528**.

Communication with Members Regarding Treatment

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

Concurrent Review

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

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

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

- Discharge needs

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

Medically Necessary

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

- Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy.
- Appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good medical practice.
- Provided for medical reasons rather than primarily for the convenience of the individual, the individual’s caregiver, or the health care provider, or for cosmetic reasons.
- Provided in the most appropriate location with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided.
- Needed, if used in reference to an emergency medical services, to exist using the prudent layperson standard.
- Provided in accordance with EPSDT requirements established in 42 U.S.C. 1396(r) and 42 CFR 441, Subpart B for individuals under age 21.
- Provided in accordance with 42 CFR 440.230.

Medical Necessity Decisions

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

Decision and Notification Standards

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

Type of Decision	Decision	Initial Notification	Notification Method
Urgent precertification	1 business days from receipt of request*	1 business days from receipt of request	Oral and/or written, dependent on type of notification
Non-urgent precertification	2 business days from receipt of the request*	2 business days from receipt of request	Oral and/or written, dependent on type of notification
Urgent concurrent review	1 calendar day from receipt of request*	1 calendar day from receipt of request*	Oral and/or written, dependent on type of notification
Retrospective review	14 calendar days from receipt of request*	14 calendar days from receipt of request	Oral and/or written, dependent on type of notification

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

If we need more facts, documents, or information to decide, we'll request it from the appropriate practitioner within the decision timeframes in the above table. The practitioner has 14 days to submit the additional information for prior authorization requests. We also notify members of requests for more information on the date we request it from the practitioner.

- If the practitioner provides the additional information within 14 days, we will approve or deny the service and notify the member, member's PCP, and prescribing practitioner according to the timeframes in the table above.
- If we don't receive the requested information within 14 days, we will approve or deny the service based upon the available information and notify the member, member's PCP, and prescribing practitioner according to the timeframes above.

Notice of Action

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

Retrospective Review

Retrospective reviews are conducted when providers or practitioners request a review after a service or procedure has been provided. Aetna Better Health of Kentucky performs retrospective reviews for services/admissions, with extenuating circumstances or that the member was determined to be retroactively eligible only. In the absence of extenuating circumstances or when a claim has already been filed, providers must submit a written request for a formal appeal as explained in the Appeals Rights. Requests for Retrospective Reviews must be submitted within twelve (12) months from the date of service or in the case of retroactive eligibility, twelve (12) months from the date the member was added to our membership roll.

Peer-to-Peer Reviews

Our medical directors participate in the utilization review process and conduct clinical review. They're available to discuss review determinations with attending physicians or other ordering providers within five (5) business days of a denial. We will notify practitioners/providers verbally, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. We provide, within one (1) business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision:

- With the medical director making the initial determination.
- With a different medical director if the original medical director cannot be available within one (1) business day.
- If a peer-to-peer conversation or review of additional information does not result in a certification, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do as such.

Authorizations

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

Authorization Confirmation

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

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

Authorizations and Claim Submission

Include the prior authorization number in the appropriate box on the claim forms for services that require an authorization. Items to consider when adding the authorization number to the claim form:

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

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

Inpatient Admissions

PCP offices or attending provider specialists must contact the Prior Authorization Department for a pre-admission review of any elective inpatient admission, home care services, certain outpatient procedures/services, or equipment that requires prior authorization.

Medical Claims Review

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

Discharge Planning

Discharge planning begins on admission and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective quality treatment interventions for post-hospital care at the earliest point in an admission to ensure appropriate utilization of services. Discharge planning is a collaborative effort between the attending physician, hospital discharge planner, Aetna Better Health clinical staff, members, ancillary providers, and community resources to coordinate care and services.

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

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

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

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

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

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

Observation Stays

Observation stays do not require prior authorization for **participating** providers.

A decision to admit from an observation stays must be made within the first 48 hours. If observation services result in an inpatient admission, notification must be made to Aetna Better Health of Kentucky UM department within one (1) calendar day.

Specialty Provider Referrals

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

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

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

Referring a member from the specialist office to another participating provider specialist must only occur with the prior approval of the member's PCP, when the services in question are of a non-emergent nature. Once this PCP approval has been obtained, the specialist is responsible for coordinating any support documentation for the referral to the provider specialist and PCP. This documentation must be available at the time of the member's visit to ensure continuity of care, timely implementation of an appropriate treatment plan as well as reduce the risk of duplicating services and/or treatments that could place the member at risk.

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

Second Opinions

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

Our members will incur no expenses for a second opinion provided by a participating or non-participating provider that have been authorized by Aetna Better Health. All second opinions by a non-participating provider require prior authorization from Aetna Better Health and may be initiated by contacting the prior authorization department.

Aetna Better Health will reimburse any non-participating provider for a second opinion at the Aetna Better Health of Kentucky Medicaid fee schedule rate in effect at the time of service. We require any service and treatment approved after the second opinion be performed by the participating provider initiating the request.

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

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

Non-Participating Provider Referral Request

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

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

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

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

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

Hysterectomy Protocol

Hysterectomies are covered only if the beneficiary has been informed verbally, before surgery that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign the Commonwealth's hysterectomy consent form. All items on the form must be completed, and the form must be signed by the beneficiary

(or representative) and the physician (MD or DO). This form must be submitted to the prior authorization department when requesting the authorization.

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

Please refer to the document library on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a copy of the Hysterectomy Consent form.

Sterilization Procedures Policy

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

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

Aetna Better Health requires prior authorization of the sterilization procedure in order to verify proper completion of the consent form.

Reimbursement cannot be made to the provider if the Commonwealth requirements are not met.

Please refer to the document library on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a copy of the Sterilization Consent form.

Elective Admissions and Outpatient Surgeries

Elective hospital admissions and select outpatient surgical procedures require prior authorization. Contacting the Aetna Better Health Prior Authorization Department prior to scheduling elective services minimizes any scheduling conflicts if issues related to network access, benefit availability and/or medical necessity arise during the prior authorization process. At a minimum, the request for services must be made five (5) working days prior to the date of service to promote a timely determination. Providing the following information at the time of the request will expedite the prior authorization process:

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

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

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

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

Urgent Admissions

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

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

Review of the clinical information for the urgent admission will be completed per existing decision and notification standards provided in this manual. Health Services will provide the determination decision for the initial admission date based on medical necessity, appropriateness of level of care and benefit availability as well as network accessibility. The Aetna Better Health Concurrent Review Clinician will review for continued stay and level of care approval. Notification of approved, reduced, or denied days will be given to the appropriate utilization management staff at the hospital, rehab, or skilled facility on the day of the review determination.

Experimental and Investigational

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

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

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

Outpatient Hospital Services

Aetna Better Health contracts with area hospitals and free-standing facilities to provide outpatient services such as, but not limited to, preventive health screenings, diagnostic testing, therapeutic and/or palliative care, and surgical services. Select services rendered in an outpatient setting require prior authorization. Please visit our provider portal or contact the prior authorization department if you are unsure if the service and/or treatment requires authorization. You may reach the prior authorization department at **1-888-725-4969**, Monday–Friday, 8 a.m.–6 p.m. ET.

When providing outpatient services, remember to:

- Verify member eligibility prior to rendering non-emergent services and/or treatments.

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

Limitations and Exclusions

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

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

Home Care Services

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

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

Durable Medical Equipment/Orthotics/Prosthetics/Supplies

Select DME, orthotics/prosthetic and supplies require prior authorization. Supplies exceeding the allowable quantity will also require prior authorization. Please refer to the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a complete authorization listing. Requests which require prior authorization should be coordinated with the member's PCP or the referring specialty care provider and be in accordance with the treatment plan. Coverage determinations will be based on medical necessity, available benefit, appropriateness of setting, and network availability. Failure to obtain prior authorization will result in claim denials for these services.

Transition of Care

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

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

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

Quality Improvement Program Description

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

Quality Management Oversight Committee (QMOC)

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

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

Quality Management/Utilization Management (QM/UM) Committee

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

- To review and make recommendations on quality improvement studies and surveys, clinical indicators, member and provider interventions.
- To review clinical criteria, practice guidelines, and protocols.
- To review demographic, disease, and program specific data and recommend clinical indicators to be monitored and interventions to be pursued.
- To review the results of quality improvement activities, monitor progress in meeting quality improvement goals, and suggest needed actions to ensure appropriate follow-up.
- To conduct a professional review activity involving the professional competence or conduct of practitioners or providers whose conduct adversely affects, or could adversely affect, the health or welfare of patients.

Goals and Objectives

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

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

- Design and maintain structures and processes that support continuous quality improvement, including systematic measurement, analysis, intervention, and re-measurement. This includes mechanisms to evaluate and improve member care outcomes.
- Comply, coordinate, and monitor for compliance with Commonwealth and federal regulations and NCQA standards. This includes attending and participating in the Commonwealth Quality Assurance and Improvement Advisory Group meetings.
- Coordinate, integrate, and communicate quality improvement activities with other departments including Member Services, Network Relations, Financial Services, Claims, Utilization Management, and Information Services.
- Monitor and evaluate medical care provided to Aetna Better Health members to ensure quality and medical appropriateness, identify over and underutilization, and ensure safety of services through prospective, concurrent, and retrospective review.
- Monitor and evaluate the behavioral health care provided to Aetna Better Health members to ensure accessibility, quality, and safety of services as well as continuity and coordination of behavioral and medical care.
- Conduct and oversee clinical and non-clinical performance improvement projects (PIPs) that demonstrate an ongoing measurement and intervention improvement in member care, service, safety, and satisfaction.
- Monitor credentialing and re-credentialing activities.
- Educate enrollees, health plan staff, and providers on the importance of Quality and Utilization Management programs and the results of non-confidential studies or reports (i.e., HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS) via newsletters and the Aetna Better Health website).
- Measure availability and accessibility to care and service at least annually.
- Measure member satisfaction and identify sources of dissatisfaction through:
 - Review and analysis of member complaint data
 - Annual member satisfaction surveys
- Measure provider satisfaction and identify sources of dissatisfaction through:
 - Review and analysis of provider complaint data
 - Annual provider satisfaction surveys
- Provide members a mechanism to offer suggestions for improving internal operations and services through participation on the Quality Member Access Committee and through the health plan's review of enrollee complaints and appeals.
- Address specific concerns identified by the plan's clinical or administrative staff.
- Establish clinical practice guidelines, including preventive health, pertinent for the population and annually measure compliance via HEDIS® measures and other applicable measures and standards.
- Measure compliance to medical record standards on a random number of physicians. Typically, this is done concurrently with the HEDIS® medical record review.
- Integrate the Quality Improvement Systems for Managed Care (QISMC) into the overall quality strategy.
- Monitor standards for oversight of sub-contracted vendors and for delegated entities for quality improvement, credentialing/ re-credentialing, utilization management and claims processing.

- Develop methods to evaluate continuity and coordination of care.
- To support objectives aimed at the development, monitoring, and servicing members with complex health needs in conjunction with Care management.
- Monitor cultural and linguistic needs to ensure processes are in place to serve a diverse membership.
- Accurately record documentation of QI investigations and activities, including documentation of quality improvement committee meetings, qualitative and quantitative reports of trends/patterns, and analysis of the trends/patterns.
- Evaluate at least annually and modify as necessary:
 - The effectiveness of quality improvement interventions for the previous year (demonstrated improvements in care and service) and trending of clinical and service indicator data.
 - The appropriateness of the program structure, processes, and objectives.
 - The work plan for the upcoming year that includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues.

Scope of Quality Improvement Program

The Aetna Better Health Quality Improvement program encompasses all aspects of clinical care and services for all members and providers. Information is reviewed on an ongoing basis. Program reviews will be conducted on targeted and randomly selected providers and diagnoses on a continuous basis. This information is then incorporated into the work plan.

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

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

- Quality management
- Utilization management
- Records management
- Information management
- Care management
- Member services/enrollee satisfaction survey
- Customer Assessment of Healthcare and Providers Systems (CAHPS) Surveys
- Provider services
- Organizational structure
- Credentialing/Re-credentialing
- Network performance
- Fraud and abuse detection and prevention
- Access and availability to care and services
- Data collection, analysis, and reporting
- Compliance with NCQA and state standards
- HEDIS® reporting requirements
- Medicaid Managed Care Performance Measures

- Preventive care
- Review of translation line utilization to identify specific cultural/linguistic needs
- Peer review
- Performance Improvement Projects (PIPs)
- Oversight of sub-contractors and delegated activities
- Continuity and coordination of care
- Annual QI work plan
- QI program effectiveness annual evaluation

Continuous Monitoring for Quality of Care and Service by Providers

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

Processes in place to continuously monitor quality of care and services include credentialing, a peer review process, medical record reviews (as applicable), and reviews of all reported adverse events and quality of care issues, such as:

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

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

- At least one (1) written notification letter is sent to the provider notifying him/her of the issue and the relevant Aetna Better Health policy, including the potential for corrective action.
- Upon determination that the provider has not complied with the Aetna Better Health participation requirements, the Medical Director may initiate corrective actions. Corrective actions may include, but are not limited to, counseling, practice restrictions, and termination of provider's participation, imposing summary suspension if such action is necessary to protect the member's health and welfare and notifying the medical group of which the provider is a member that corrective actions have been imposed.
- The Medical Director may refer the issue to an appropriate committee for review and recommendations. If the recommendation is contract termination, the provider will be notified immediately by certified mail.
- The Medical Director or designee or the Credentialing Committee may recommend termination of the Aetna Better Health provider for substandard performance, failure to comply with administrative requirements, or any other reason.

The Medical Director or designee may immediately suspend or restrict any provider if the Medical Director determines that the health of Aetna Better Health members or any individual referred by Aetna Better Health to the provider for care is in imminent danger or jeopardy because of the actions or inactions of a participating provider. Also, in his/her sole discretion, the Medical Director (or designee) may determine an Aetna Better Health provider may be subject to

disciplinary action, including termination pursuant to the credentialing plan, including immediate suspension or restriction of the provider's participation status, during which time Aetna Better Health will investigate to determine if further action is required.

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

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

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

Practitioner Sanctioning Policy

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

Provider On-Going Monitoring

The Aetna Better Health policy and process for ongoing provider monitoring, including on-site visits and medical record quality reviews, are based on recommendations from the National Committee for Quality Assurance (NCQA), regulatory requirements and Kentucky Medicaid requirements. The policy and procedure are reviewed, revised if necessary, and approved by the Executive Quality Improvement Committee on an annual basis. Provider on-site evaluations may be completed by a Network Relations Manager and/or a registered nurse from the Quality Improvement Department. Medical record reviews are completed by registered nurses in the Quality Improvement Department.

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

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

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

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

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

Clinical Practice Guidelines

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

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

The disease management conditions that are managed by Aetna Better Health and the clinical guidelines the programs are based on include:

- Alcohol abuse – National Institute on Alcohol Abuse and Alcoholism
- Asthma – National Heart, Lung and Blood Institute. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
- Attention Deficit/Hyperactivity Disorder – American Academy of Pediatrics (AAP)
- Chronic kidney disease – Kidney Disease Improving Global Outcomes (KDIGO) and the National Kidney Foundation
- Chronic pain – 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
- Chronic obstructive pulmonary disease – Global Initiative for Chronic Obstructive Pulmonary Disease and the American Lung Association
- Coronary artery disease – American College of Cardiology, American Heart Association Task Force, American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons
- Diabetes – American Diabetes Association Standards of Medical Care in Diabetes (2017)
- Heart health/Heart failure – American College of Cardiology and the American Heart Association
- Major depressive disorder – American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition 2010
- Behavioral Health
 - Antipsychotic use in children – American Academy of Child and Adolescent Psychiatry, American Board of Internal Medicine, and the American Psychiatric Association

The Clinical Practice and Preventive Health guidelines are available on the Aetna Better Health of Kentucky website at <https://www.aetnabetterhealth.com/kentucky> on the provider tab in the Document Library. A hard copy of the guidelines is available to providers upon request. A provider can request a copy by contacting their Network Relations Manager. Disclosure of clinical guidelines is not a guarantee of coverage.

Provider Participation

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

Medical Record Management

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

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

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

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

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

Copy or Access to Member Medical Records

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

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

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

Confidentiality

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

Release of Information

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

Storage

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

Transfer of Medical Records

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

PCP panel listings, including new members, are available on our secure provider portal at

<https://www.aetnabetterhealth.com/kentucky> and available upon request. Aetna Better Health encourages providers to use this list to contact new members for appointments and request copies of their medical records.

Medical Records Retention

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

Member Safety

In November 1999, the Institute of Medicine's (IOM) Committee on Quality Health Care in America released a comprehensive report regarding medical errors in the health care system, "To Err is Human: Building a Safer Health

System.” The report cited startling statistics including that 44,000 Americans die annually due to medical errors. It presented recommendations that call for action to reduce these errors at a number of different levels. Specifically, it suggested that health care organizations and accrediting bodies do the following:

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

Aetna Better Health has responded to these developments by including an emphasis on member safety in the Quality Improvement program and developing policies and procedures to meet the requirements of the final rules that implement Section 2702 of the Member Protection and Affordable Care Act (72 Federal Register 32816 (2011)). Several activities are in place to monitor aspects of member safety. The National Quality Forum’s recommended adverse event list has been combined with the CMS list of hospital-acquired conditions and other events identified by Aetna Better Health to be used for quality of care adverse event monitoring and reporting. Providers’ credentials are verified in accordance with NCQA standards plus monitoring of disciplinary action against providers occurs on an ongoing basis.

Trauma-Informed Care

Aetna Better Health of Kentucky understands that many of our members suffer the consequences of traumatizing events and of adverse community experiences. They need to work with providers whom they trust and with whom they feel safe. We are in the process of identifying providers that are trauma informed. We will be mirroring the SAMSHA model for Behavioral Health/Physical Health integration by recognizing the different levels of being trauma informed.

- I. Level 1 is a foundational awareness where practitioners understand how trauma effects people and where all staff feel the office is a safe and trusted place to work.
- II. Level 2 is an enhanced routine clinical where practitioners incorporate level 1 knowledge into their daily practice with tools that address trauma and social determinants of health (SDoH). The organization practices thriving and flourishing, building resilience and minimizing the risks of trauma.
- III. Level 3 is basic trauma-informed care where practitioners add trauma specific treatments, services and supports. The provider organization provides screenings for trauma and adverse community conditions and has identified resources for staff.
- IV. Level 4 supports advanced trauma-informed care where the practitioner integrates physical and behavioral health, addressing complex trauma, member demographics, and conditions where people live, work, and play within routine clinical practice. The provider organization collaborates with trauma-informed individual practitioners and implements a Trauma-Informed Center of Excellence that offers state-of-the-art and innovative treatments, services and supports for people with complex needs. They may focus on improving health outcomes for a well-defined population.
- V. Level 5 is an organization that is trauma transformed with close or full collaboration between trauma-informed individual practitioners on inter-disciplinary care teams. There is also a high level of collaboration between behavioral and physical health providers.
- VI. Level 6 is the highest level of transformation where the provider organization collaborates across sections to meet the complex needs of people, they serve within a larger community context. Small scale interventions provide invaluable assistance for individuals, but the provider organization remains focused on social determinants that perpetuate poor health at the community level.

If you wish to partner with us or are interested in resources on how to become Trauma Informed, please contact your Network Relations Manager at **1-855-300-5528**.

Advanced Health Care Directive

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

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

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

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

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

The law:

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

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

Types of Advanced Health Care Directives

There are two types of advanced health care directives:

- Living will
- Durable power of attorney for health care

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

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

Who needs an advanced directive?

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

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

Where can I get an advanced health care directive?

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

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

The following resources may also be helpful:

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

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

Frequently Asked Questions

1) Why do health plans collect HEDIS® data?

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

2) How are HEDIS® measures generated?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Helpful HEDIS® Documentation Tips for Providers

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

Providers may also contact the HEDIS® Department to schedule on-site or webinar based HEDIS® training. Please call **1-855-300-5528** to speak with a HEDIS® Outreach Coordinator to schedule this training.

SECTION SEVEN – Billing Guidelines

Claim Forms (CMS and UB)

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

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

Please refer to NUBC (National Uniform Billing Committee – UB-04 for us) for complete detailed information about paper claim submission and refer to the 837 Institutional Implementation Guide by Washington Publishing Company (May 2006) for any EDI related issues.

Box 1
Paper – Bill to Provider should bill as shown above in Box 1
Bill to Provider is REQUIRED
Address MUST BE the physical address services were rendered
Address MAY NOT BE PO BOX address
EDI – Loop 2010AA

Box 2
Paper – Pay to Provider should be billed as shown above in Box 2
Pay to Provider is only required if different from Bill to Provider.
Address should be the address to direct payment to Address MAY be PO Box address if the Service Facility Locations or the Bill to Provider's address is physical location
EDI – Loop 2010AB

Box 3
NDC: National Drug Code
Paper: If the facility populates a NDC code – it must be a valid National Drug Code (NDC) – the code must be entered in Box 43. The 'N4' qualifier should precede the 11-digit NDC code. No spaces or dashes are allowed.
EDI – Loop 2410 Segment: UN Element: N4 (5-4-2 data format)

Box 4
Taxonomy Code
Paper – Billing Provider's Taxonomy
Paper left column = B3
Paper – middle column = 10 character Taxonomy Code
EDI Billing provider – Loop 0000A – PRV01 'B' PRV02 – 'PKC' qualifier
PRV03 = 10 characters Taxonomy Code

Box 5
Paper – Federal Tax ID is Required
EDI – Loop 2010AA element REF02
EDI Qualifier element REF01=E1

Box 6
NPI –
Paper- Billing Provider's NPI
EDI – NPI – Loop 2010AA NM108 = XX NM109
NOTE: Billing Provider's Taxonomy code should be populated in 81CC a

Boxes 76, 77, 78 and 79
Attending/Operating/Other Name and NPI
Paper
Box 76 – Attending Name and NPI are required for Inpatient Bill Types
Box 77 – Operating Name and NPI are required when surgical procedure are billed
Box 78-79. If any of these boxes are populated, then their NPI is required
EDI
Attending – Loop 2310A element NM108-xx NM109-10-digit NPI number
Operating – Loop 2310B element NM108-xx NM108-10-digit NPI number
Other – Loop 2310C element NM108-xx NM109-10-digit NPI number
Taxonomy Code – Loop 2310A – PRV01 "AT" PRV02 "PKC" qualifier PRV03 = 10 character Taxonomy Code.

Boxes 81CC a-d
Taxonomy Code
Paper – Billing Provider's Taxonomy
Paper left column = B3
Paper – middle column = 10 character Taxonomy Code
EDI Billing provider – Loop 0000A – PRV01 'B' PRV02 – 'PKC' qualifier
PRV03 = 10 characters Taxonomy Code

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



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Submission Example
Please refer to the NUCC (National Uniform Claim Committee Guide) for complete detailed information on paper claim submission as well as the 837 Professional Implementation Guide for any Electronic Data Interchange (EDI) issues. <http://www.nucc.org/>

<input type="checkbox"/> MEDICA	<input type="checkbox"/> MEDICARE			<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN	<input type="checkbox"/> OTHER	1. INSURED'S ID NUMBER (For Program in Box 1)
<input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (Medi-Cal)		<input type="checkbox"/> (Member ID)		<input type="checkbox"/> (Member ID)	<input type="checkbox"/> (ID)	<input type="checkbox"/> (ID)	<input type="checkbox"/> (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT BIRTH DATE MM / DD / YY		4. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street)		
CITY				STATE		CITY		STATE
ZIP CODE				TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				9. IS PATIENT'S CONDITION RELATED TO?		11. INSURED'S POLICY GROUP OR FECA NUMBER		
10. OTHER INSURED'S POLICY OR ID NUMBER				12. RESERVED FOR NUCC USE		13. RESERVED FOR NUCC USE		
14. DATE OF CURRENT & LATEST INJURY OR PERSONAL INJURY				15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
17. AGENCY OF ORIGIN (NDC, PROVIDER OR OTHER SOURCE)				18. NDC (NDC Code)		19. ICD-10 CODE		14. RENDRING PROVIDER'S TAXONOMY CODE IS ENTERED IN BOX 24J (SHADED AREA) AND THE ZZ QUALIFIER IN 24I. NOTE: DO NOT POPULATE 24I IF BOX 31 AND 33 ARE THE SAME.
20. NDC - NATION DRUG CODE The Provider should populate a valid NDC for drugs. The code must be entered in the shaded area of Box 24. The "N4" qualifier must precede the 11-digit NDC code. No dashes or dashes are allowed.				21. ICD-10 CODE The ICD-10 code must contain a valid ICD-10 code.		22. RENDRING PROVIDER'S TAXONOMY CODE IS ENTERED IN BOX 24J (SHADED AREA) AND THE ZZ QUALIFIER IN 24I. NOTE: DO NOT POPULATE 24I IF BOX 31 AND 33 ARE THE SAME.		
23. FEDERAL TAX ID NUMBER				24. PATIENT'S ACCOUNT NO.		25. ACCEPT ASSIGNMENT?		26. TOTAL CHARGE
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS				28. SERVICE FACILITY LOCATION INFORMATION		29. BILLING PROVIDER BPO & PH #		
30. RENDRING PROVIDER'S LAST NAME, FIRST NAME				31. SERVICE FACILITY NAME Physical Location City, State, ZIP		32. BILLING PROVIDER NAME - Payment Location - City, State, Zip		
33. NPI of SERVICE FACILITY				34. NPI of Billing Provider		35. ZZ QUALIFIER - 10-DIGIT TAXONOMY		

General Claims Information and Requirements

Aetna Better Health of Kentucky encourages all participating providers to submit electronic claims whenever possible.

Electronic claim submission offers providers the fastest and most efficient claims adjudication and reduces office paperwork and mailing costs. Contact your Network Manager/Network Relationship Manager for additional information.

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

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

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

Taxonomy

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

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

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

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

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

Ordering, Referring, Prescribing, and Admitting (ORPA)

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

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

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

Provider Type		Provider Type	
60	Dentist	78	Certified Nurse Practitioner
64	Physician	80	Podiatrist
74	Nurse Anesthetist	85	Chiropractors
77	Optometrist	95	Physician Assistant

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

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

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

This requirement also applies to out-of-state ordering, referring, and/or prescribing providers. These providers must

also be enrolled in Kentucky Medicaid for services to be paid by Fee for Service (Traditional) Medicaid and with the contracted managed care organizations should services be provided to impacted Medicaid recipients.

With dates of service beginning **April 1, 2017**, the ordering, referring, and prescribing information is required. As of **July 1, 2017**, claims that are not billed correctly will be denied and will need to be corrected and resubmitted.

Claim Coding

Claims must be submitted with valid CPT, HCPCS, revenue codes, modifiers, and NDC if applicable.

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

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

Components of a “Clean” Claim

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

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

Coordination of Benefits (COB)

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

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

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

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

COB with Medicare: Claims will be paid the lesser of Aetna Better Health of Kentucky’s primary payment or member responsibility.

COB with Commercial: Claims will be paid the difference of the Aetna Better Health of Kentucky’s allowance and the Commercial carrier’s payment.

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

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

Balance Billing/Hold Harmless

Providers shall accept payment in full for covered services rendered to members and such amounts as are paid by Aetna Better Health. Providers cannot charge or bill members for administrative or program fees associated with a covered service. In no event (including non-payment by Aetna Better Health for covered services rendered to members by provider for whatever reason, including claim submission delays and/or UM sanctions, insolvency of Aetna Better Health, or breach by Aetna Better Health of any term or condition of the agreement under which provider participates) shall provider bill, charge, or collect a deposition from, seek compensation, remuneration or reimbursement from, or have any course against any member or a person (other than Aetna Better Health) acting on a member's behalf for covered services eligible for payment, nor shall provider bill a member or a person (other than Aetna Better Health of Kentucky) acting on a member's behalf for the difference between the covered charge and the negotiated rate or the amount provider has agreed to accept as full payment under the agreement for any amounts Aetna Better Health may owe provider or for any monies in excess of applicable co-payments, deductibles or coinsurance, except as otherwise noted below. Provider shall in no event seek payment from any member for any service for which Aetna Better Health has denied payment on the grounds that provider has failed to comply with the requirements with respect of such service, including, but not limited to, the failure of Provider to obtain required preauthorization. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.

Provider shall collect from the member and may retain only co-payments and deductibles.

In the event a Member agrees in advance in writing to pay for a NON-Medicaid service, then the provider can bill the member. A standard, detailed, easy to understand, release form must be signed by the Member at the time of service and must specifically state the services or procedures that are not covered by Medicaid.

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

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

Provider further agrees that:

- The no balance billing provision shall survive the termination of the participation regardless of the cause giving rise to termination and shall be construed to be for the benefit of members and Aetna Better Health.

- This no balance billing provision supersedes any oral or written contrary agreement now existing or hereafter entered between provider and a member or a person acting on his/her behalf.

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

Authorization and Claim Submission

Dates of service on the claim should fall within the pre-authorized service date range, if authorization is required.

Authorization does not guarantee payment. Issues related to billing errors and member eligibility may cause a claim and/or claim line to adjudicate with a non-payment status.

Claim Submission Address for Paper Claims

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

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

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

Electronic Claim Submission (EDI)

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

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

Clearinghouse	Payor ID #	Claim type	Contact number
Change Healthcare	128KY	UB and CMS	1-877-469-3263

Electronic Claims are not considered received until the claims have passed clearinghouse edits and are accepted into the Aetna Better Health of Kentucky system. Aetna Better Health has partnered with Change Healthcare to provide electronic services to our providers.

Electronic Submission of Corrected Claims

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

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

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

Timely Filing Guidelines

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

Proof of Timely Filing

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

- A computer printout, which shows the claim, was generated and submitted to Aetna Better Health within the timely filing limits
- A copy of the EDI report showing the electronic carrier accepted the claim within the timely filing limits
- In case of providers who do not have a computerized billing system, other valid and credible documentation showing the claim was generated and submitted to Aetna Better Health within timely filing
- A copy of the other insurance carrier's EOB received twelve (12) months after the date of service but less than six (6) months after the other insurance carrier's adjudication date
- Claim front-end rejections are not considered clean claims

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

For claims not meeting the above acceptable proof of timely filing criteria, providers may initiate a request through the complaint and appeal process to have a specific claim and supporting documentation reviewed.

Note: A copy of a Kentucky Medicaid remittance advice or other Kentucky Medicaid managed care plan remittance advice is not considered acceptable documentation to override untimely filing. Member eligibility is date specific and should be confirmed at every visit or encounter.

Electronic Funds Transfer (EFT)

EFT is an option for claims payment at no cost to our providers. Providers receive payment efficiently deposited directly into the provider's bank account. However, a print-ready PDF of your paper remittance advice is available through the provider portal at <https://www.aetnabetterhealth.com/kentucky>.

To enroll in EFT, complete the form found on the Aetna Better Health website

<https://www.aetnabetterhealth.com/kentucky> or simply contact your Network Manager/Network Relationship Manager.

Electronic Remittance Advice (ERA)

ERA allows providers to auto post payments quickly and efficiently. To enroll for ERA, the provider should call their practice management software (PMS) vendor or hospital information system (HIS) vendor for details. Aetna Better Health ERAs are made available from CHANGE Healthcare Business Services (Change Healthcare).

To enroll in ERA, complete the form found on the Aetna Better Health website

<https://www.aetnabetterhealth.com/kentucky> or contact your Network Manager/Network Relationship Manager.

Remittance Advice

Aetna Better Health generates twice weekly Remittance 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 the remittance advice through the secure provider portal.



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

PROVIDER NAME: STREET ADDRESS: CITY, STATE ZIP

PROVIDER NAME TIN: Beneficiary Plan: Program/Name

If you have any questions:
Please contact the Claims Department at 1-855-360-5528 or visit our website at <http://www.aetnabetterhealth.com/kentucky>

Remit Date: MM/DD/YYYY

Beginning Balance:	0.00
Processed Amount:	122.64
Discount/Penalty:	-2.40
Net Amount:	120.24
Refund Amount:	116.50
Amount Received:	0.00
Amount Paid:	236.64
Ending Balance:	0.00
Check #:	1234567
Check Amount:	236.64

Remittance Summary

Days of Service (From - Thru)	Rate Code	Med Code	Rev Code	FFS	Units	Billed Amount	Disallowed Amount	Allowable Amount	Co-Pay	Out-Of-Pocket	COB Paid	Processed Amount	Discount/Penalty	Net Amount
11/18/03	80023			1	1	34.00	25.33	0.00	80.00	100.00	100.00	0.00	0.00	192.00
11/18/03	80013			1	1	18.00	8.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	90780	89		1	202.00	133.94	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	2100			20	20.00	17.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	2120			1	10.00	8.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	21026		200	CAP	110	402.00	395.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Claim Total:						1356.04	596.81	759.23	0.00	0.00	0.00	0.00	0.00	0.00

Sub-Description:
186 - Payment denied because the diagnosis was listed for the date(s) of service reported

Other Payer/Plan Name: Medicare COB Paid
Penny Lantz Uga
ID #: 8610730000
Address: P.O. Box 6523, Fayette, KY 40524-0523

Remit Totals:

Billed Amount	Disallowed Amount	Allowable Amount	Co-Pay	Out-Of-Pocket	COB Paid	Processed Amount	Discount/Penalty	Net Amount
1356.04	596.81	759.23	0.00	0.00	0.00	1120.24	-2.40	1117.84

KY Provider Remit Document for Mock Up



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

PROVIDER NAME: TIN: 123456789

If you have any questions:
Please contact the Claims Department at 1-855-360-5528 or visit our website at <http://www.aetnabetterhealth.com/kentucky>

Remit Date: MM/DD/YYYY

Beginning Balance:	0.00
Processed Amount:	122.64
Discount/Penalty:	-2.40
Net Amount:	120.24
Refund Amount:	116.50
Amount Received:	0.00
Amount Paid:	236.64
Ending Balance:	0.00
Check #:	1234567
Check Amount:	236.64

Remittance Summary

Days of Service (From - Thru)	Rate Code	Med Code	Rev Code	FFS	Units	Billed Amount	Disallowed Amount	Allowable Amount	Co-Pay	Out-Of-Pocket	COB Paid	Processed Amount	Discount/Penalty	Net Amount
11/18/03	80023			1	1	34.00	25.33	0.00	80.00	100.00	100.00	0.00	0.00	192.00
11/18/03	80013			1	1	18.00	8.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	90780	89		1	202.00	133.94	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	2100			20	20.00	17.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	2120			1	10.00	8.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11/18/03	21026		200	CAP	110	402.00	395.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Claim Total:						1356.04	596.81	759.23	0.00	0.00	0.00	0.00	0.00	0.00

Sub-Description:
186 - Payment denied because the diagnosis was listed for the date(s) of service reported

Other Payer/Plan Name: Medicare COB Paid
Penny Lantz Uga
ID #: 8610730000
Address: P.O. Box 6523, Fayette, KY 40524-0523

Remit Totals:

Billed Amount	Disallowed Amount	Allowable Amount	Co-Pay	Out-Of-Pocket	COB Paid	Processed Amount	Discount/Penalty	Net Amount
1356.04	596.81	759.23	0.00	0.00	0.00	1120.24	-2.40	1117.84

KY Provider Remit Document for Mock Up

[81]

Proprietary

Prepayment Review Process

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

Below is a description of prepayment review process. Physicians and other healthcare professionals may have the right to dispute results of reviews.

Prepayment review process

ABHKY (or its designee) conducts prepayment reviews of healthcare professionals' records related to services rendered to ABHKY members. During these reviews, provider and/or facilities are asked to allow ABHKY access to medical records and billing documents that support the charges billed.

ABHKY's prepayment reviews look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the healthcare industry, including the Medicaid programs.

Examples include, but are not limited to:

- Excessive billed charges or selection of the wrong code(s) for services or supplies
- Billing for items or services that should not have been or were not provided based on documentation supplied
- Unit errors, duplicate charges, and redundant charges
- Insufficient documentation in the medical record to support the charges billed
- Experimental and investigational items billed
- Lack of medical necessity to support services or days billed
- Uncovered services per the member's benefit plan, Aetna policies, Medicare policies or Medicaid policies
- Lack of objective clinical information in the medical record to support condition for which services are billed
- Items not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.

These reviews also confirm that:

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

Reviews and records requests

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

Records submission

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

Healthcare professionals who do not submit the requested documentation may receive a technical denial which will result in the claim being denied until all information necessary to adjudicate the claim is received.

Outcome

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

Collection Advice/Remittance

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

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

Please make your refund check payable to Aetna Better Health and mail to the following address:

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

In the example:

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

In addition:

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

Health Plan: Kentucky									
Pay to Provider: XXXXXXXX									
Prov ID: 95499KYIP									
Advance Dates: 5/29/2018 - 5/29/2018									
Provider Status: ACTIVE									
Show/Hide Claims									
Trans Type	Advance	LOB	Trans Date	Advance Amt	Adj Trans Amt	Running Balance	Current Balance	Days Outstanding	
ADVANCE	Claim adjusted (Claim ID)	Kentucky - Medicaid & CHIP	5/29/2018	\$1,090.73		\$989.75	\$989.75	35	
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	REVERSED	(\$936.60)	\$0.00		Reversal of Claim # is XXXXX
5/29/2018 Negative balance created									
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	REVERSED	(\$936.60)			
Amount adjusted (Claim Paid)									
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	PAID	\$297.69	\$0.00		
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	PAID	\$297.69	\$0.00		
Recoupment on 9/19/2018									
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	PAID	\$187.09	\$0.00		
INTERNAL ADJ	FFS	Kentucky - Medicaid & CHIP	9/19/2018	\$1,090.73		\$888.75	\$888.75	35	
Claim ID	Pat Acct No	Carrier/Member ID	Member Name	Provider Name	Status	Claim Paid	Interest/Discount	Provider Refused	Remit Comments
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	PAID	\$100.98	\$0.00		
Recoupment of \$ 100.98									

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

Recoveries

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

In the event Aetna Better Health determines that a provider was overpaid, Aetna Better Health shall provide written or electronic notice to the provider with the amount of the overpayment, a member identifier, date(s) of service, Aetna Better Health's reference number for the claim, and the basis for determining that an overpayment exists. If a refund is not received within sixty (60) days of the postmark date/electronic delivery date of our notice, or if the Provider has not disputed the overpayment recovery request, the amount of the overpayment will be recouped from future payments through offset.

Provider can send a notice of disagreement with the overpayment recovery request within sixty (60) days from the postmark date/electronic delivery date and submit additional relevant information to Aetna Better Health. In such instance, Aetna Better Health shall not proceed with the recoupment until the dispute is resolved. Disputes shall be resolved within thirty (30) days of receipt through Aetna Better Health's provider appeals process outlined in this Provider Manual.

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

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

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

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

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

On-site Meeting

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

Claim Specific Requirements

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

Anesthesia Start/Stop Times

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

Assistant Surgeon

Assistant surgeon charges are indicated on a provider's claim (CMS 1500 form, block 24D) with an 80, 81, or 82 modifiers. Modifiers 81 and AS are not reimbursable per Kentucky Medicaid.

Bilateral Procedures

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

Modifiers

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

Immunizations

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

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

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

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

Per current billing instructions and as of dates of service January 1, 2014, vaccines will be paid by the following:

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

Clinical Claims Editing

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

The major areas reviewed as part of claim editing include:

- **CPT Unbundling** – Procedural unbundling occurs when two or more procedure codes are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. When this occurs, the component procedures will be denied and re-bundled to pay the comprehensive procedure.
 - If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and re-bundled to the comprehensive code.
 - If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied, and the comprehensive code will be added to the claim for payment.
- **Incidental procedures** – Procedures that are performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.
- **Mutually-exclusive procedures** – Two (2) or more procedures that are billed, by medical practice standards, should not be performed or billed for the same member on the same date of service.
- **Duplicate procedures** – Procedures that are billed more than once on a date of service.
- **Assistant surgeon utilization** – Determination of reimbursement and coverage.
- **Evaluation and management service billing** – Review the billing for services in conjunction with procedures performed.
- **Emergency room evaluation and management services** – Review the billing of high-level evaluation and management services against ACEP guidelines.

Multiple Surgical Procedures

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

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

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

Submission of Itemized Billing Statements

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

If the charges on the itemized bill are less than 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 \$50,000 and above require itemized bills as part of our audit process. Claims submitted without the itemized bills will be denied. The claims will deny as "Itemized Bill Missing." The claim will need to be resubmitted with the itemized bill before the claim will be reviewed.

Paper claims can be submitted to:

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

Legal Owner of Tax Identification Number (TIN)

Each provider's legal name and billing address are loaded in the Aetna Better Health provider database from the information on your submitted W-9 form. If there is a change to the provider's name, address, TIN or legal owner of the TIN, you must submit an updated W-9 form to your Network Manager/Network Relationship Manager. Your submission should include the effective date of the change. Aetna Better Health should receive the change at least sixty (60) days prior to the effective date of the change. The legal owner of the TIN as listed on line 1 of the W-9 should be listed in Box 33, Line 1 of the CMS form, or Block 2 of the UB-04 form. If a claim is submitted with conflicting information in Field 33, Line 1 of the CMS form, or Block 2 of the UB-04, the claim will be denied by Aetna Better Health.

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

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

Provider Identification numbers (i.e., Tax Identification Number (TIN), Federal Tax Identification Number (FTIN), Employer Identification Number (EIN)) containing your personal social security number (SSN) may present unnecessary risks to your identity. Please request new identification numbers if you are using your personal SSN. This will ensure your SSN is not exposed over the course of standard business practices and protect yourself from unnecessary harm.

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

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

What is an Appeal?

An appeal is the way you can have actions we take reviewed. There are different types of appeals. A provider appeal, as defined by The Commonwealth of Kentucky, is an appeal about provider payment or a contractual issue. Some adverse benefits determinations which can be appealed include:

- A dispute with a claim we failed to reimburse or reimbursed at less than the amount you expected.
- A request for authorization of a service that we denied or did not respond to within a reasonable time.
- Dissatisfaction with any of our policies or procedures, or a decision we make.

No punitive action or retaliation will be taken towards a member or provider in response to an appeal or a complaint. Also, we will never discriminate against a member or provider for filing a complaint or appeal.

Provider Appeal Process

When appealing, please include the following:

- Clear explanation about why you are filing an appeal.
- Supportive documentation that may include clinical information.

How to File

We have processes designed to let you tell us when you are dissatisfied with a decision we make. You may file a complaint or an appeal. We've outlined each process below. There are several ways you can get your complaint or appeal to us. You can:

- Fax your appeal to us at **1-855-454-5585**. Our fax is secure and is available twenty-four (24) hours a day, every day. This is the fastest and most preferred method to send an appeal.
- Call us to tell us about your appeal or complaint at **1-855-300-5528** (TTY users dial **711**/TDD users dial **1-800-627-4702**). We're open Monday through Friday from 7a.m. to 7p.m. ET.
- File a written complaint to us at:

Aetna Better Health of Kentucky
Attn: Complaint and Appeal Department
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

- You can email us at: KYAppealandGrievance@aetna.com

- You can submit an appeal through the Provider Portal.

For standard appeals, we'll always send you a letter within five (5) business days to let you know we received your information. If, at any time, you're concerned that we didn't receive your fax, letter or call notes, you can call us. Our phone number is **1-855-300-5528** (TTY users dial **711**/TDD users dial **1-800-627-4702**).

Clinical complaints and appeals reviews are completed by health professionals who:

- Hold an active, unrestricted license to practice medicine or in a health profession
- Are board certified (if applicable)
- Are in the same profession or in a similar specialty as normally manages the condition, procedure or treatment concerned in the case, and
- Are neither the same reviewer that made the original decision nor the subordinate of the person that made the first decision

Administrative cases are about decisions we make that involve something other than medical details. These include decisions based on policy and procedure or claim payment issues. Disputes about any other non-clinical aspect of our business' functions fall into this category also. Appropriate health plan staff review these appeals based on the issue at hand.

Conduct of the Review

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

Aetna Better Health of Kentucky
Attn: Complaint and Appeal Department
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

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

Resolution of the Appeal

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

Provider External Review

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

An external review is your right to have our decision reviewed by an outside reviewer. The reviewer is chosen by the State of Kentucky. A review may be requested when we issue an adverse decision on an appeal you submit regarding (a) a claim involving a medical necessity determination, (b) a claim involving whether the given service is covered by the Medicaid program, or (c) a claim involving whether the provider followed the MCO requirements of the covered service.

You can send your request electronically, by fax, or by postal mail. If you wish to send your request by mail, send your request and the required documentation (listed below) to the address below:

Aetna Better Health of Kentucky
Attn: Complaint and Appeal Department
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

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

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

When you submit a request for an external review, include a letter that:

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

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

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

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

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

Provider Grievances

A complaint about payment issues or contractual issues is a provider complaint. A provider complaint is the way you express your disagreement with:

- how we paid a submitted claim
- an authorization that was denied in whole or in part
- any of our policies or procedures
- any other decision we make regarding health plan function

You can send us your information to file a complaint by mail, fax, or email (see section 2.9.3). We may ask you to send supporting documentation so we can investigate your concern as thoroughly as possible. It's important that you include a general statement about the basis for your complaint.

We use different staff to review complaints, based on the issue. For example, staff from our contractors look into issues regarding vision or dental benefits, and the Member Services department investigates issues with our service delivery.

Within five (5) business days of the day we receive your complaint, we'll send you a letter letting you know it's been received. Within 30 calendar days from the day we receive your complaint, we'll send you a resolution letter explaining what we've learned about your concerns. If you ask, we can respond by faxed letter if we have your fax number. In some cases, we may extend the complaint response time by 14 days. We'll only extend the case if it's beneficial to you. If the extra time we use for investigating the complaint isn't acceptable to you, you have the right to file a grievance to dispute the extra days. No punitive action or retaliation will be taken towards a member or provider in response to a complaint or an appeal. Also, we will never discriminate against a member or provider for filing a complaint or appeal.

Fraud, Waste and Abuse Guidelines

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

Kentucky Medicaid Managed Care Fraud Definition

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

Kentucky Medicaid Managed Care Abuse Definition

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

Program Description

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

Some common examples of member fraud are:

- Letting someone else use their insurance card
- Using multiple physicians to acquire abusive drugs

Some common examples of provider fraud are:

- Billing for services not provided
- Billing for more expensive services than actually provided

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

Federal Deficit Reduction Act of 2005 (DRA)

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

pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”).

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

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

Behavioral Health

Aetna Better Health of Kentucky covers behavioral health services. These services include specialized behavioral health services provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, and mental health rehabilitation service providers (public or private). We also cover inpatient hospital services for acute medical detoxification.

Aetna Better Health of Kentucky is committed to having an integrated care model that looks at all aspects of person – physical, emotional, lifestyle, beliefs, and values. We treat behavioral and physical health together.

Behavioral Health Access Standards

Behavioral health & substance use services	
Appointment type	Access/Appointment Standard
Emergent	Within 6 hours for non-life-threatening emergency services
Urgent care	Within 48 hours
New member appointments	Within 10 days
Aftercare appointments	Within 7 days after hospital discharge
Other referrals	Within 60 days

Behavioral Health Care Providers

Communication between behavioral health care providers and the member’s PCP helps to ensure members receive coordination of care. The sharing of clinical information promotes quality health care and a comprehensive treatment plan to assess for coexisting medical conditions, medication interactions or other medical concerns. Behavioral health care providers shall refer members with known or suspected and untreated physical health problems or disorders to such member’s PCP for examination and treatment, with the member’s or the member’s legal guardian’s written consent. Behavioral health care providers shall send initial and quarterly (or more frequently if clinically indicated) summary reports of a member’s behavioral health status to the member’s PCP, with the member’s or the member’s legal guardian’s consent.

Behavioral Health and Substance Use

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

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

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

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

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

Behavioral Health Programs

Behavioral health programs and social work services are also available through Aetna Better Health Social Workers. For information about our integrated care management programs or to make a referral, call **1-888-604-6106**.

Prescribing Outpatient Medications for Members

The Aetna Better Health pharmacy benefit covers medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides FDA approved outpatient prescription medications that are clinically proven to be safe and effective.

Our formulary assists in ensuring quality of member care and containing costs for the member's drug benefit. Providers and pharmacists are encouraged to refer to the formulary when selecting prescription drug therapy for eligible members.

Pharmacy Benefit Manager

CVS/Caremark administers the prescription drug benefit for Aetna Better Health of Kentucky. Pharmacies should process claims for Aetna Better Health of Kentucky members through the TelePAID System with the Member ID number, RxBIN 610591, RxGROUPTX8831. This information along with the prescriber and dispensing pharmacy's NPI number are mandatory fields for successful claims processing. The CVS/Caremark contact numbers and web site are:

- RXBIN.....**610591**
- RXPCN.....**ADV**
- RXGRP.....**RX8831**
- CVS Pharmacy Help Desk: **1-855-319-6290**
- Pharmacy Prior Authorization phone number: **1-855-300-5528**
- Pharmacy Prior Authorization fax numbers: **1-855-799-2550**
- **<https://www.aetnabetterhealth.com/kentucky>**

Prescribing Practitioners

Aetna Better Health of Kentucky requires that prescribers have valid and active NPI (National Provider Identification Number) and valid, active MAID (Medicaid Identification Number). Prescriptions from prescribers who do not have both numbers will reject at the point of sale.

Pharmacy and Medication Management

Aetna Better Health of Kentucky employs clinical edits for claim adjudication functions as a payer based on requirements from the Commonwealth of Kentucky and Centers for Medicare Medicaid Services (CMS) as required for legal compliance to regulations.

The following management edits are utilized to promote safety, efficiency and effectiveness:

- Quantity limits – a 31-day supply or course of therapy as related to the medication
- Step edits – a requirement to use an alternative medication first
- Age edits – may be attached to some medications due to safety recommendation for administration by the FDA
- Prior authorization – may be required to establish medical necessity
- Maximum allowable cost (MAC) for medications may be used to provide financial stewardship to generic available multi-source medications
- Generic medications to be first choice, when available
- Medicaid fee schedules, as included by the Kentucky Department of Medicaid Services, for use in reimbursement of in-office medical services
- Quality management using the tools of pharmacy for results to derive quality for HEDIS® and NCQA

Pharmacy Network

The Aetna Better Health pharmacy network includes pharmacies ranging from local independently owned and operated stores to major regional and national pharmacy chains. These chains include, but are not limited to, the following:

- CVS
- Walgreens
- Walmart
- Rite Aid
- Kroger

For a complete listing of all participating pharmacies, please visit the Aetna Better Health website:

<https://www.aetnabetterhealth.com/kentucky>.

Covered Drugs and Services

Aetna Better Health of Kentucky has a preferred drug list located at <https://www.aetnabetterhealth.com/kentucky>.

This preferred drug list is also available by calling the Member Services phone number as listed on the back of the member's card or by contacting your Network Relations Manager.

The preferred drug list is constructed of select medications which meet the strict standards of safety, efficacy, and best value using comparative models through the Aetna Better Health of Kentucky Pharmacy and Therapeutics Committee.

When possible, it is requested that a drug from this preferred list be selected for the member's use. Please note that select drugs from the Preferred Drug List (PDL) do require a prior authorization.

This list of preferred medications is updated at least monthly. It may be updated more often based on the needs of prescribers and members.

Non-preferred medications are also available through our prior authorization process. Non-preferred medications may require step therapy as well as supportive documentation showing the benefit of the drug to the member.

A limited selection of OTC (Over the Counter) medications are available to the member. Members must have a prescription from their prescriber for their drug benefit to apply. OTC medications are limited to a 30-day supply.

Compound medications may be provided based on the medical necessity. Aetna Better Health of Kentucky provides diabetic test strips, lancet and insulin syringes.

Mandatory Generics

Aetna Better Health requires the use of generics, when available. Requests for exceptions must clearly document specific reasons for medical necessity and appropriateness. In order to obtain a brand name product, which has an equal generic, providers will be required to file a FDA MedWatch response form located at:

<https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf>

Step Therapy

In some cases, the drug that is prescribed may require step therapy. Step therapy requires that a similar drug must be tried and failed first.

Quantity Limits

Aetna Better Health of Kentucky applies quantity limits on medications to ensure safety, promote cost-effective dosing and deter waste and abuse. Most prescription medications are limited to the lesser of a 31-day supply or 120 doses. Quantity limits are reviewed, and set based on the FDA-approved dosing and medically accepted uses. For example, medications FDA-approved for once daily administration are typically limited to one (1) dose per day. Some medications may also be limited at a specified quantity per fill.

- Opioid medications with a Morphine Equivalent Dose (MED) > 200 will require a Medical Director Review.

If you have any additional questions or comments about this or other pharmacy benefits, please feel free to contact the Pharmacy Department **1-855-300-5528**. To obtain prior authorization, please call our Pharmacy Prior Authorization Department at **1-855-300-5528**.

Formulary

Formulary documents can be found on Aetna Better Health of Kentucky website at <https://www.aetnabetterhealth.com/kentucky>. Our members and providers are notified of formulary changes via our member newsletter, provider newsletter and on the website at <https://www.aetnabetterhealth.com/kentucky>. We update this list on a regular basis, annually and as needed. We will send you a notice about any changes that may negatively affect members.

Note: Formulary documents may use brand names for informational reference. Any formulary documents are the most current list at the time of publication and are subject to change, as we periodically review our drug formulary. Some medications may require prior authorization.

Pharmacy Help Desk

Questions regarding pharmacy coverage can be directed to the Aetna Better Health pharmacy Prior Authorization Department at **1-855-300-5528**. Member Service Representatives are available Monday through Friday, 7 a.m. to 7 p.m. ET. The pharmacy help desk is available 24 hours a day, 7 days a week.

Providers may also fax prior authorization requests to **1-855-799-2550**. We are able to receive and log fax requests 24 hours a day, 7 days a week.

In addition to phoning or faxing in a Pharmacy Prior Authorization, providers can also submit Electronic Prior Authorization (ePA) through Cover My Meds at <https://www.covermymeds.com/main/>. Providers may contact Cover My Meds via the website or their toll-free number at **1-866-452-5017** to enroll.

Prior authorization requests must be accompanied by all supporting documentation of medications tried, outcome and dates. Medication given as samples does not count as trial or failure of a medication. A copy of the Prior Authorization form can be downloaded from the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky>.

Self-Administered Injectable Medications

Self-injectables such as Glucagon, Imitrex, Insulin, and bee sting kits are covered under the member's pharmacy benefit. Some self-administered injectables require prior authorization and may also require procurement via network specialty pharmacy.

When a prior authorization is approved for a self-administered injectable you will be provided with information on procuring that medication directly from one of our specialty vendors.

Our formulary documents found on our website at <https://www.aetnabetterhealth.com/kentucky> lists the covered self-administered injectable medications covered on the formulary.

Specialty Medications

Aetna Better Health Specialty Drug Program is managed through CVS Health Specialty Pharmacy. The Specialty pharmacies fill prescriptions and ship drugs for complex medical conditions, including hepatitis C, multiple sclerosis, hemophilia, rheumatoid arthritis, and most cancer drugs. Medications provided through CVS specialty pharmacy include injectable, oral, and inhaled drugs.

The Specialty Drug Program provides care management services to your members, including:

- 24 hours a day, seven (7) days a week access to a pharmacist
- Disease-specific education and counseling by the CareTeam™. The CareTeam™ are clinical professionals who review dosing and medication schedules, identify injection issues, provide education of potential side effects and provide information to help your patient to manage their medical condition.
- Care coordination
- Delivery of Specialty drugs to your patient's home and/or your office in temperature-controlled packaging with the required supplies i.e. needles, syringes, and alcohol wipes or patients can be directed to drop off and pick up most of their prescriptions at any CVS Pharmacy location (including those inside Target® stores).

NOTE: Specialty medications are subject to Prior Authorization. To find a list of our network Specialty pharmacies and medications covered under the specialty pharmacy benefit, please visit our website at

<https://www.aetnabetterhealth.com/kentucky>.

Non-Covered Drugs

The following is a listing of non-covered drugs:

- Drugs that are not medically necessary.
- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purposes other than treatment for severe acne and agents used to treat baldness.
- Experimental and investigational medication, drugs with no approved Food and Drug Administration (FDA) indications and drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other peer-reviewed medical literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- Any drug marketed by a company (or labeler) that does not participate in the Fee for Service (FFS) Medicaid Drug Rebate program in accordance with Section 1927 of the Social Security Act, 42 U.S.C.A 139r-8.
- Any product designated by the FDA as a Drug Efficacy Study Implementation (DESI) drug.
- Drugs for the treatment of sexual or erectile dysfunction. Amendments to Title XIX of the Social Security Act prohibit Federal Financial Participation (FFP) under Medicaid for these drugs when used to treat sexual or erectile dysfunction.
- Drugs used to treat infertility.
- Drugs used to treat weight loss.

Copays

Some benefits through Aetna Better Health of Kentucky require copay from the member. Members should always show their membership card to the provider and to the pharmacy in order to reduce the member's share of cost. A request for preferred medications and generic preferred medication should be considered whenever possible.

Prescription Drug Type		Copay Amount
Home infusion therapy	Limited to administration by parent or guardian in the home	\$0
Prescription Drugs	Generic Drugs	\$1
	Preferred brand name	\$4, Exception, when brand is preferred over generic, copay will be \$1
	Non-preferred brand name	\$4
	Family planning	\$0
	Tobacco cessation	\$0
	Certain Antipsychotics and Long-Acting Injectable Antipsychotics	\$1
	Diabetic Meters	\$0
	Diabetic -- test strips, control solutions, insulin needles, lancets, etc.	\$4 copay for 1st fill, \$0 for 2 nd fill and beyond PER DAY

Care Management Integrated (CARE MANAGEMENT AND DISEASE MANAGEMENT)

Integrated Care Management (ICM) is designed to identify our most bio-psycho-socially complex and vulnerable members with whom we have an opportunity to make a significant difference. We engage these members in integrated care management programs to remove or lessen barriers that limit their ability to manage their own health and well-being, to educate them about their chronic conditions, and to help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports.

Autonomy and active self-management of acute and chronic conditions is encouraged where clinically appropriate, with tools and education directed at each member's unique needs and health literacy. A well-trained case manager serves as the single point of contact for the member. We collaborate with the member, member support and/or integrated care team to create a plan of care that includes mutually agreed upon member-centered goals, actions for the member/member supports. The case manager and the care team arrange for both covered and non-covered services to be coordinated for the member.

All members will receive person-centered outreach and follow-up, from those who are healthiest to those who are the sickest or most at-risk due to their medical, behavioral, and/or social comorbidities; pregnant women, mothers, and children in TANF; the aged, blind, and disabled (ABD); members who have a chronic illness, severe and persistent mental illness, or disability. The Care Manager may work with the member telephonically or meet with the member in a setting that is best for the member.

The integrated care management program is "Integrated" as it reflects our belief that care management must address the member's medical, behavioral, and social needs in an integrated fashion and must address the continuum of acute, chronic, and long-term services and supports needs. Case managers assist members in coordinating medical and/or behavioral health services as well as those available in the community and/or that are not covered in the member's benefits package.

Any psychosocial issues and cognitive limitations that impact the member are incorporated into their individualized care plan as are the cultural practices and beliefs that are most important to the member. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the case manager and the member better understand what has prevented full engagement with a suggested clinical treatment or plan of care. Once these issues are identified by the member and informed by the care team, true individualized and collaborative care planning can begin.

The ICM Program manages the unique needs of each member's experience. Whether they have short-term acute needs or long-standing chronic health issues, or need information, resources or care coordination the program can be tailored to that specific member's situation. Using available information, we employ clinical algorithms and case manager judgment to recommend a level of integrated care management that is best suited to address the member's needs. All Medicaid program types are included (e.g. TANF, ABD, CHIP, dually enrolled) and drive the services and interventions that the member receives.

If you have patients that need Integrated Care management or you have any questions about these services, Call Member Services at **1-855-300-5528**, 7a.m. to 7p.m. ET, Monday–Friday, and ask to speak to a Case Manager. Involvement in the ICM program is voluntary. Members have the right to opt out of the ICM program at any time.

Dental Services

Dental services are covered for eligible Aetna Better Health members. Aetna Better Health is contracted with Avēsis Third Party Administrators, Inc. for the provision of these services. Providers, members or other responsible parties may verify dental benefits by contacting:

Avēsis' Member Services at **1-855-214-6776** or www.avesis.com.

The Avēsis website also contains important information including, but not limited to, Dental Alerts, eligibility verification, claims submission, and claims status.

Members with dental benefits may self-refer to participating dental providers for routine office level dental services. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury are also covered services.

Prior Authorization

Aetna Better Health requires prior authorization for dental procedures that are scheduled as outpatient and/or inpatient cases. For example, facility costs associated with dental care under anesthesia would require prior authorization from Aetna Better Health.

For questions, please call our PA department at **1-888-725-4969** or send via secure fax at **1-855-454-5579**.

Some services provided by a licensed M.D. may be covered by Aetna Better Health and not Avēsis (e.g. trauma to the mouth/jaw, etc.).

Care Management and Support Available from Aetna Better Health of Kentucky

Aetna Better Health educates members about the importance of EPSDT screenings. Aetna Better Health sends member reminders when members are due for screenings and provides follow-up reminders if screenings are not completed. Aetna Better Health also provides scheduling assistance for those members who are eligible.

Aetna Better Health also provides care management services, including care management programs, disease management programs, and social work assistance for our members with special needs, complex medical conditions, or chronic medical conditions. Please refer to page 101 for additional information about our care management program.

Special Needs Case Management

Members with special health care needs are those members who have ongoing special conditions that require a course of treatment or regular care monitoring. An assessment is completed on all members identified with a special health care need. The assessment consists of identifying issues, such as, but not limited to, eligibility status, PCP and/or specialty provider access, coordination of care for durable medical equipment (DME), therapy, home health services, behavioral health, and/or dental access. Further evaluation includes the member's and/or family's ability to remain compliant with a treatment plan and/or follow-up care requirement, general understanding of the clinical and quality of life risks when intervention is not provided, and the complexity of the clinical case. The Special Needs Coordinator educates the parent/guardian on Kentucky Medicaid Managed Care benefits.

Children in Commonwealth of Kentucky custody, foster care, or guardianship are evaluated for integrated care management to ensure that the coordination and documentation of care is consistently performed in a timely manner.

Completion of Special Reports or Forms for Members

Preparation of special reports, including, but not limited to, return to work/school forms, etc., are not considered reimbursable by Aetna Better Health and are not billable to the member.

Dental Services

Dental services are covered for eligible Aetna Better Health members. Aetna Better Health is contracted with Avesis Third Party Administrators, Inc. for the provision of these services.

EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program for children. In the Commonwealth of Kentucky, it is divided into two components: EPSDT Screenings (discussed below) and EPSDT Special Services.

The EPSDT Screening Program provides routine physicals and well-child checkups for Medicaid eligible children at certain specified ages. It is considered preventive care. Children are checked for medical problems early. Specific tests and treatments are recommended as children grow older.

EPSDT Special Services are services for Members under the age of 21 not covered by the Kentucky Medicaid Program. EPSDT Special Services are provided as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8. Those EPSDT diagnosis and treatment services and EPSDT Special Services which are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization by the Contractor, as specified in 907 KAR 1:034, Section 9. Approval of requests for EPSDT Special Services shall be based on the standard of Medical Necessity specified in 907 KAR 1:034, Section 9.

EPSDT Covered Services

The areas of health care that are checked include: preventive check-ups, growth and development assessments, vision, hearing, dental, immunizations, and laboratory tests.

Children should receive health check-ups regularly or before the following ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and once a year for ages 3–20.

Documentation of these evaluations should be recorded in the child's medical record.

EPSDT Tracking/Member Outreach

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow the child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian regarding the importance of these services. If the parent/guardian continues to refuse the service, the child's medical record must document the reason the service was not provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests or lab work was refused. By fully documenting in the child's medical record the reason for not providing these services, the provider may bill a full medical screening service even though all components of the full medical screening service were not provided.

Aetna Better Health requires providers maintain adequate fiscal and medical records that fully disclose services rendered, retain these records for at least seven (7) years, and make them available to appropriate Aetna Better Health staff, state, and federal officials on request.

EPSDT Billing/Reporting

EPSDT screening services must be reported with the age-appropriate evaluation and preventative medicine CPT Codes along with the EP modifier. An appropriate procedure code must be submitted on the CMS 1500 form. Please contact your Network Relations Manager to determine if there are any exceptions for EPSDT special services.

The primary diagnosis should be submitted as the first diagnosis in field 21 of the CMS claim form. Additionally, this same primary diagnosis must be reflected on the appropriate line item diagnosis item (field 24 E). In most instances, the primary diagnosis will be V20.2.

The appropriate services associated with the EPSDT screening must be rendered and the codes for these services included in the claim with an EP modifier accompanying **each code**. EPSDT claims must be billed on a CMS 1500 form. Please refer to the billing instructions at www.chfs.ky.gov.

Aetna Better Health will provide coverage for an office visit performed at the same time as the EPSDT screening if the child was seen for a reason other than the EPSDT screening, (i.e., sick child visit). Additionally, Aetna Better Health will provide coverage for an EPSDT screening performed during a prenatal visit for members aged 20 and under.

Modifier – EP (EPSDT Services)

Modifier EP is available for use with evaluation/ management codes when the member is under age 21 on the date of service. Using the EP modifier is required for EPSDT services provided to a member. Modifier SL must be used when billing Vaccines for Children (CFC) immunizations. Refer to Section 2, I., for more information on billing VFC services. Modifier 26 is no longer used.

EPSDT Practitioner Eligibility

Fully trained EPSDT providers who meet the requirements set forth under 907 KAR 11:034 and who are supported by adequately equipped offices to perform EPSDT services are deemed eligible.

EPSDT Referrals

Should the PCP be unable to provide all the components of the EPSDT exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within the Aetna Better Health of Kentucky network that is qualified to treat the condition. It is the responsibility of the referring agencies/providers to follow up on this referral to determine if treatment was initiated. Quality audits may also examine if providers are initiating this follow-up. The following list includes specialists and agencies to whom a member can be referred:

- Dentists
- Pediatricians
- Sub-specialty agencies/physicians
- Specialty agencies
- Health department clinics
 - Tuberculosis (TB) clinic
 - Women Infants and Children (WIC) program
 - Maternity clinic

- Family planning
- Lead clinics
- Behavioral health providers

Components of a Full Medical Screen

The following are required for an exam to qualify as an EPSDT exam:

- A comprehensive unclothed physical examination.
- A comprehensive health and developmental history including assessment of both physical and behavioral health developments.
- Health education (including anticipatory guidance).
- Appropriate immunizations according to age.
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated).
- Lead screening at every EPSDT visit from six (6) months of age to six (6) years of age (A serum lead level lab test should be completed no less than by one (1) year of age and again by two (2) years of age regardless of the outcome of lead screening. Lead levels should also be completed whenever the lead screening identifies the member as at risk for an elevated lead level).
- Hearing screening.
- Vision screening.
- Dental screening beginning with the first tooth eruption (but no later than one (1) year of age even if a tooth has not erupted).

The next sections provide details on the components of the exam.

Interval History/Parent's Concerns/Child's Concerns

The purpose of a health and developmental history is to gather information about diseases and health problems for which no standard screening test has been developed and to compile historical information about the child and the family. Answers to a standard set of questions can identify those children who may be at a substantial risk of a significant health problem. The health and developmental history should also provide information about siblings, growth history, conditions suffered by blood relatives, previous medications, immunizations, allergies, and a developmental history of the child as well as other family members.

Nutritional Assessment

The assessment of a child's nutritional status and eating habits (and the use of alcohol and tobacco) are taken at the time of the physical examination. Evaluation is also suggested for the following groups:

- Children who demonstrate weight loss or no weight gain over a period.
- Children who are considerably overweight in proportion to their height or greater than the 85th percentile according to the Center for Disease Control Body Mass Index (CDC BMI) for age growth chart. Refer to the document library on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a copy of the BMI for age growth chart.
- Other variations from expected growth parameters, such as weight for age and height for age, below the 5th percentile.
- Disease in which nutrition plays a key role, such as cardiovascular disease, hyperlipidemia, gastrointestinal disorders, hypertension, metabolic disorders, physical and mental handicaps affecting feeding, allergies and

surgery. If information suggests dietary inadequacy, obesity, or other nutritional problems, further assessment is indicated, including:

- Family, socioeconomic or any community factors
- Determining quality and quantity of individual diets (i.e., dietary intake, food acceptance, meal patterns, methods of food preparation/preservation, and utilization of food assistance programs)
- Further physical and laboratory examinations
- Preventive treatment and follow-up services, including dietary counseling and nutrition education
- Provide intervention for those children considered to be at risk (85th percentile of BMI)

Unclothed Physical Examination

The unclothed physical examination includes specific screening elements as appropriate for the child's age and health history:

- General appearance
- Body measurements
- Skin evaluation
- Blood pressure
- Auscultation of heart and palpation of femoral arteries
- Pulmonary evaluation/auscultation of the lungs, chest configuration, and respiratory movements
- Pulse
- Abdominal evaluation of musculature, organs, masses
- Urogenital evaluation
- Vocalization and speech for appropriate age
- Facial features evaluation
- Neurological evaluation, including gross/fine motor coordination
- Orthopedic evaluation, including muscle tone and scoliosis
- Ears, eyes, nose, and throat inspection

Anticipatory Guidance

Health education is a required component of screening services and includes anticipatory guidance. Health education and counseling to parents/guardians as well as children are required and designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles, practices, and accident and disease prevention.

Lab/Immunizations

Appropriate immunizations for the child's age and health are required under the EPSDT program. Refer to the Advisory Committee on Immunization Practices at <http://www.cdc.gov/vaccines/schedules/index.html>. Laboratory procedures appropriate for the individual's age and population groups are required under the EPSDT program. Analysis of the hemoglobin/hematocrit, urinalysis, and TB skin test are included in the all-inclusive fee for screening.

The following lab procedures are recommended for the appropriate population group:

- **Sickle cell test** - As of August 1988, infants are screened for the presence of sickle hemoglobin (hemoglobin S). For children born prior to 1988, it is recommended that hemoglobin electrophoresis is performed, and results are recorded in the child's medical record. Diagnosis for sickle cell trait may be done with sickle cell preparation or a hemoglobin solubility test. If a child was properly tested once for sickle cell disease, it is not necessary to repeat the test.
- **Tuberculin test** - Tuberculosis services include screening, diagnosis and treatment. Aetna Better Health providers shall follow current CDC/American Thoracic Society Guidelines: Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children, or their equivalent, including the use of Mantoux Purified Protein Derivative (Mantoux PPD) skin test to screen for tuberculosis.
- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.
- All members receiving treatment for tuberculosis disease shall be referred to the local public health agency's tuberculosis contact for directly observed therapy. Aetna Better Health shall communicate with the local public health agency's tuberculosis contact to obtain information regarding the member's health status. Aetna Better Health shall communicate this information to the provider. Aetna Better Health shall be responsible for care coordination and medically necessary follow-up treatment.
- All laboratory tests for tuberculosis shall meet the standards established by the Center for Disease Control, Department of Health and Social Services.
- **Hemoglobin/hematocrit** - Recommended at 6–12 months or as indicated.
- **Urinalysis** - As indicated.
- **Serum cholesterol** - A serum cholesterol determination should be considered in those with a family history of early heart disease and/or hypertension and stroke.

Lead Screening & Testing

All children should have a serum lead test by one (1) year of age and again by two (2) years of age. Additionally, lead screening should occur at every EPSDT visit from six (6) months of age to six (6) years of age.

Development Personal-Social and Language

The Department of Health and Senior Services and Centers for Medicare and Medicaid (CMS) define a developmental assessment as the range of activities surrounding the examination of the child, adolescent and young adult to determine whether they fall within the normal range of achievement for the child's age group and cultural background. The developmental assessment is performed at the time of the screening for all ages. Information from the parent or others with knowledge of the individual, direct observation and talking with the member are utilized to assess the individual's behavior.

It is recommended to include the following elements in the developmental assessment of children of all ages:

- Communication skills, focusing on expression, comprehension, and speech articulation
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children/adolescents, parents, and other adults
- Cognitive skills, focusing on problem-solving and reasoning

Fine Motor/Gross Motor

It is recommended to include an assessment of fine motor and gross motor development for children of all ages.

Hearing

Children should be tested using an appropriate test such as the Weber, Rinne, or Puretone Audiometric evaluation along with history from the parent/guardian.

Vision

Administration of age-appropriate vision assessment:

- General external examination and evaluation of ocular motility
- Gross visual acuity examination with fixation test
- Testing light sense with pupillary light reflex test
- Intraocular examinations with ophthalmoscope

Standardized testing methods include: Visual acuity test for distance on each eye. The Illiterate E test, the STYCAR (Screening Test for Young Children and Retardates), or the Lippman Matching Symbol Chart - HOTV Eye Chart may be utilized. Children four (4) and five (5) years of age should be tested at 10 to 15 feet.

To determine muscle balance, a cover test and the Hirschberg test (corneal light reflex) should be given. Parents should be asked if they have noticed the child's eyes turn in or out.

All individuals ages 5–20 years should be evaluated for distance visual acuity utilizing the Illiterate E or the Snellen letters for a linear fashion. The test should be at 20 feet.

Individuals who wear glasses should be tested while wearing their glasses.

Dental

The American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend that children should see a dentist:

- When the first tooth appears or no later than the first birthday
- Twice a year for preventive services
- If there is evidence of infection, inflammation, discoloration, malformation of the dental arches, malformation or decay of erupted teeth

Emergency Services

Emergency Care shall be available twenty-four (24) hours and day, seven (7) days a week.

An emergency medical condition is a medical or behavioral health condition manifesting itself by acute symptoms of enough severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency

- Injury to self or bodily harm to others
- With respect to a pregnant woman having contractions: (1) inadequate time to affect a safe transfer to another hospital before delivery, or (2) transfer may pose a threat to the health or safety of the woman or the unborn child

Aetna Better Health may contact members and providers that inappropriately seek routine and non-emergent services through emergency room visits to educate the members on visiting their PCP for routine services and/or treatments.

Members that utilize ground ambulance transportation under the prudent lay person's definition of emergency will not require authorization for the ambulance service.

Note: The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending provider determines that the member is sufficiently stabilized for transfer or discharge.

Out of Service Area Care

Aetna Better Health will reimburse non-participating providers for the evaluation and/or stabilization of emergency conditions according to Commonwealth guidelines, as described above and in accordance with Section 6085 of the Deficit Reduction Act of 2005. Aetna Better Health will accept the attending provider's determination and continue reimbursement at an emergent level if the member's medical stabilization has not been achieved.

Urgent Care Services

Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment

Family Planning

The Aetna Better Health confidentiality policy must extend to minors when the minor is requesting family planning or other reproductive health services. The parent/guardian of minor requesting information must demonstrate the member's consent prior to the release of information regarding family planning and/or other reproductive health services.

All information shall be provided to the member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible within a maximum of 30 days. If it is not possible to provide complete medical services to members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within ten (10) days. Adolescents shall be assured that family planning services are confidential, and that any necessary follow-up will assure the member's privacy.

Aetna Better Health members can receive family planning services from any Medicaid enrolled provider and is not restricted to receiving services from an Aetna Better Health participating provider.

Sterilization procedures follow the Commonwealth of Kentucky guidelines and are not covered for members under the age of 21. Members must sign the sterilization consent form at least thirty (30) days but not more than 180 days prior to

the date of the sterilization procedure. Please refer to the CHFS website:

<http://chfs.ky.gov/dph/info/dpqi/phpr+forms+and+teaching+sheets.htm> to access the appropriate form for this procedure.

Health and Disease Management Programs

Based on the member's needs, case managers use condition-specific assessments and care plan interventions to assist them with chronic condition management, thereby including traditional "disease management" within the ICM process rather than it being managed separately. Members with diabetes, COPD, heart failure, asthma, depression, chronic kidney disease, and coronary artery disease are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, and concurrent review/prior authorization referral, as well as member and provider referral.

Lock-In Program

The Lock-In Program is designed to provide support to our members who need assistance in managing healthcare needs through the establishment of a medical home and providing structured access to specialty providers and medications through the Medicaid program. Members will be locked-in to designated providers for a period of two (2) years. Aetna Better Health will monitor claims and pharmacy use of Lock-In members at least annually after the initial 24-month Lock-in period.

Members can be enrolled into one or more providers that will support the member's establishment of a medical home and prescription habits. These providers consist of:

- 1 PCP (primary care provider)
- 1 Pharmacy
- 1 Emergency department

A designated primary care provider must meet the following requirements:

- A. Must meet the normal time and distance access standards. See Section 4.1 for Provider Access Standards.
- B. Shall provide and manage service for the Lock-In member's health care needs.
- C. If the Lock-In member requires a covered service that the designated primary care provider cannot provide, the Lock-In provider will refer the member to an Aetna Better Health provider who can provide the necessary service. It is important the designated provider completes a Lock-In referral form and/or notifies the Lock-In staff with the provider the member is being referred. This form can be located on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky>. Click the For Providers Tab and then search under the Document Library.
- D. Must complete periodic assessment of the Lock-In member's compliance with the terms of the Lock-In Program.

A designated Lock-In pharmacy and/or Emergency Department must also meet the normal time and distance standards for the community in which the member resides. Members may access emergency services from any provider.

Prior to a service, providers should determine whether a member is in the Lock-In Program as Lock-In recipients are restricted to certain providers. Treatment of a Lock-In member for non-emergency services by a provider who does not serve as the member's assigned provider may not be reimbursed by Aetna Better Health.

Obstetrical - Maternity Care Overview

Once an Aetna Better Health member is found to be pregnant, the provider must notify our integrated Care Management Department by calling Member Services **1-855-300-5528** or via fax at **1-855-454-5044**, using the Aetna Better Health Maternity Risk Screening form. Please refer to the Document Library on the Aetna Better Health of Kentucky website at <https://www.aetnabetterhealth.com/kentucky> for a copy of the form.

- One ultrasound is allowed after 16 weeks with notification only. Any additional ultrasounds require prior authorization and will be reviewed for medical necessity.

High Risk OB Program

Our goal is to have healthy mothers and babies. To meet that goal, Aetna Better Health has developed a maternal and child program in conjunction with the members' obstetrical providers. This program promotes prenatal screenings and interventions in order to identify potential high-risk factors and monitor prenatal visit compliance.

Cribs for Moms Program

Aetna Better Health offers a care management pregnancy coaching program with an incentive of a "free" portable crib for pregnant women who attend a prenatal visit with their obstetrical provider within 42 days of enrollment AND participate in the maternity care management program.

The provider's office is asked to complete a Cribs for Moms program form to allow the new mother to receive a Pack 'n Play style portable crib for each infant delivered. Aetna Better Health encourages moms to eliminate all items in the crib to keep baby safe during sleep. This program is provided to pregnant moms participating in the program prior to delivery.

Members may call the Member Services Department to enroll early by asking for care management for this benefit at **1-855-300-5528**.

Obstetrics Observation/Inpatient Admission Authorization

During pregnancy, the maternity provider assumes the responsibility of coordinating the member's care for OB-related conditions. Aetna Better Health authorizes 4-day admission stays for routine vaginal deliveries and uncomplicated cesarean deliveries. The attending physician and mother may determine that an earlier discharge is in the best interest of the family.

Newborns

Most newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health by the Cabinet for Health and Family Services, except when eligibility does not allow automatic enrollment. Most newborn infants will be deemed eligible for Medicaid and will be automatically enrolled with Aetna Better Health as individual members for sixty (60) days. Deemed eligible newborns are auto enrolled in Medicaid and enrollment is coordinated within the Cabinet.

The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). The information is used to auto-enroll the deemed eligible newborn within twenty-four (24) hours of birth.

Unless the mother selects a different Medicaid managed care plan, newborns born during the mother's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health. The Commonwealth enrollment process must be completed to ensure timely and accurate claims processing of newborn claims. Any service payment issues

related to newborn care should be directed to your Network Manager/Network Relationship Manager at **1-855-300-5528**.

Newborn claims will be denied until a valid Commonwealth of Kentucky Medicaid ID number is on file for the newborn. Hospital social service coordinators or local DCBS caseworkers usually initiate the process of educating and facilitating the mother of an Aetna Better Health newborn to complete the Medicaid enrollment process. However, it is the mother's responsibility to ensure a newborn is enrolled with Medicaid within sixty (60) days of birth.

Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the Commonwealth. Delayed newborn enrollment may cause a delay in claim reimbursement for providers. Contacting the Commonwealth and/or your Network Relations Manager will facilitate the correction of the delayed enrollment and instructions on the process to submit your claim(s) will be provided.

If the mother has not selected a PCP for the newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

Sterilization Procedures Policy

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

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

Aetna Better Health requires prior authorization of the sterilization procedure in order to verify proper completion of the consent form.

Reimbursement cannot be made to the provider if the Commonwealth requirements are not met. Please refer to the Document Library on the Aetna Better Health website at <https://www.aetnabetterhealth.com/kentucky> for a copy of the Sterilization Consent form.

Pediatric Sexual Abuse Examination

Pediatric sexual assault forensic examinations are reimbursed by Kentucky Medicaid fee-for-service program. Authorization is required.

Reference Laboratory Services

Outpatient reference laboratory services must be directed to a contracted laboratory provider. Please refer to the provider search on the Aetna Better Health of Kentucky website at <https://www.aetnabetterhealth.com/kentucky> for a complete listing of contracted laboratories.

Transplant Management

Transplant services are part of the Kentucky Medicaid managed care benefit. All transplant requests must be pre-authorized by Aetna Better Health and must be performed at an Aetna Better Health approved transplant facility. Note: not all Aetna Better Health network hospitals are approved transplant facilities.

Transportation Services

Transportation services are available for eligible members through the Human Service Transportation Delivery (HSTD) program. CHFS contracts with HSTD to provide this service. More information regarding non-emergency transportation services can be found at www.chfs.ky.gov.

Non-Emergency Medical Transportation

Aetna Better Health is responsible for the provision of non-emergent medical transportation by stretcher for members.

Non-emergent medical transport by stretcher requires a prior authorization, which includes:

- Stretcher van transport
- Elective transports from place of residence to non-emergent medical services
- Elective transports from a nursing home to a medical facility

Non-Emergent Ambulance Transport Requires Prior Authorization

The Concurrent review staff members are responsible for coordinating and, if applicable, authorizing non-emergent facility-to-facility and facility to place of residence ambulance transportation for members. After-hours transport from medical facilities to place of residence do not require authorization.

Emergency Transportation

Emergency transportation does not require prior authorization and is provided for all members by calling **911** or the local emergency service number.

Vision Services

Aetna Better Health of Kentucky contracts with Avēsis for vision services to our members. Avēsis administers full comprehensive eye care services, which includes routine and medical vision services. Medical eye care coverage can include the detection, treatment and management of ocular and/or systemic conditions that produce ocular or visual symptoms. Covered members may seek care from a participating provider.

Member Eligibility Verification

Members are eligible to receive one exam of eye health and visual acuity per calendar year. Members have a material allowance per calendar year for lenses and frames. Elective contact lenses are not covered. A medically necessary contact lens fitting is covered if criteria are met. Members do not have an out-of-network benefit.

Vision Services Program Fact Sheet

Covered benefits are administered in accordance with the Avēsis policies and procedures in effect upon the date of service. Procedure codes are only covered within your scope of licensure as well as the current laws, rules and regulations as determined by the Commonwealth and Federal Government.

Conditions Covered under Aetna Better Health Medical Benefit

Examples of conditions may include, but are not limited to:

• Ocular hypertension	• Retinal nevus
• Glaucoma	• Cataract
• Conjunctivitis	• Macular degeneration
• Corneal dystrophy	• Corneal abrasion
• Blepharitis	• Chalazion-Hordeolum

For more information, please call your Network Relations Manager or you may call Avēsis at **1-855-214-6776**.

Claim Submission for Vision Services

Claims for vision services should be submitted to:

Avēsis

P. O. Box 38300

Phoenix, AZ 85069

Phone: **1-855-214-6776**

Provider Experience Contact List

<p>Region 3 <i>Behavioral Health Providers</i></p> <p>All Regions <i>Community Mental Health Centers</i></p>		<p>Dustin Johnson Network Manager 502-648-6526 Johnsond38@aetna.com</p>
 <p>Region 5, 6, & 7 <i>Behavioral Health Providers</i></p>		<p>Holly Smith Network Relationship Manager 815-641-7411 Smithh3@aetna.com</p>
<p>Baptist Health System</p>		<p>Cristy Sheppard Network Manager 502-263-8420 SheppardC1@aetna.com</p>
 <p>Kentucky Primary Care Association (KPCA) Association of Primary Care Physicians (APCP) The Physicians Network (TPN) Ephraim McDowell Cooperative Care Network</p>		<p>Sammie Asher Network Relationship Manager 606-401-1573 Ashers@aetna.com</p>
<p>Regions 1 <i>Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, McCracken</i></p> <p>Regions 2 <i>Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster</i></p> <p>Providers in the state of Indiana</p>		<p>Gina Gullo Network Relationship Manager 502-612-9958 Rigullo@aetna.com</p>
 <p>Region 3A <i>Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, Washington</i></p> <p>Norton Healthcare System All other states excluding: IN, OH, TN, VA, & WV</p>		<p>Trista Gibson Network Manager 606-305-2705 GibsonT1@aetna.com</p>

<p>Region 3B <i>Jefferson County</i></p>		<p>Connie Edelen Network Relationship Manager 502-240-2122 Czedelen@aetna.com</p>
<p>Region 4 <i>Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne</i></p> <p>Providers in the state of Tennessee</p>		<p>Abbi Wilson Network Manager 270-816-0893 Wilsona8@aetna.com</p>
<p>Region 5A <i>Anderson, Bourbon, Fayette, Franklin, Garrard, Harrison, Jessamine, Mercer, Nicholas, Owen, Scott, Woodford</i></p>		<p>Jennie Handley Network Manager 513-659-9061 Handleyj@aetna.com</p>
<p>Region 5B <i>Boyle, Clark, Estill, Garrard, Jackson, Lincoln, Madison, Montgomery, Powell, Rockcastle</i></p>		<p>Becky Bowman Network Relationship Manager 502-214-0399 BowmanB@aetna.com</p>
<p>Region 6 <i>Boone, Campbell, Gallatin, Grant, Kenton, Pendleton</i></p> <p>Region 7 <i>Bath, Boyd, Bracken, Carter, Elliot, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan</i></p> <p>CHI Saint Joseph Medical Group (Kentucky One) Providers in the state of Ohio and West Virginia</p>		<p>Jacquelyne Pack Network Manager 606-331-1075 Jmpack@aetna.com</p>
<p>Region 8 <i>Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, Wolfe</i></p> <p>Providers in the state of Virginia</p>		<p>Krystal Risner Network Relationship Manager 606-687-0310 Risnerk@aetna.com</p>

We would like to offer a heartfelt thanks to the many people whose work is driving innovation and improving lives of our member's in Kentucky. From the strong network of individual practitioners, groups of providers, hospitals, pharmacies, and everyone in between, you play such an important role in bringing healthcare to those we serve in each region and county.

Thank you for your dedication to our members. Your skills and compassion bring hope to our patients and families. Working together for the good of the patient, we cannot fail.

Thank you – Your Provider Experience Team

SECTION THIRTEEN – Acronyms

Acronyms	Full Name / Definition
ABA	Applied Behavioral Analysis
ACA	Affordable Care Act
ALF	Assisted Living Facility
Atypical Provider	CMS defines this as providers that do not provide health care, such as Taxi Services, Durable Medical Equipment, and Respite Care as some examples
BCBA	Board Certified Behavioral Analyst
BHT	Behavioral Health Treatment
CAQH	Coalition for Affordable Quality Health Care
CAP	Capitation – the payment of a fee or grant to a doctor, school, or other person or body providing services to a number of people, such that the amount paid is determined by the number of patients, students, or customers
CHIP	Children’s Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
DHSS	Department of Health and Social Services
DME	Durable Medical Equipment
DMS	Department of Medicaid Services
DOS	Date of Service
DRG	Diagnosis Related Group
EDI	Application used to view claims, along with services rendered
EFT	Electronic Funds Transfer
ERA	Electronic Remittance Advice
ETA	Estimated Time of Arrival
EPSDT	Early and Periodic Screening Diagnosis and Treatment
FFS	Fee for Service
FQHC	Federally Qualified Health Center
HCBS	Home and Community Based Services

HCFA (hick-fa)	Type of a claim - HCFA 1500 forms. Typically used for physician or non-facility type services.
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IPA	Independent Physician Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOS	Length of Stay
LTCSS	Long-Term Care Supports and Services
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLR	Medical Loss Ratio
Non-Par	Nonparticipating Provider
NP	Nurse Practitioner
NPI	National Provider Identification – 10-digit number assigned to Physicians and/or Groups
NPES ("N-peez")	Free directory of all active National Provider Identifier (NPI) records
OIG	Office of the Inspector General
PA	Physician Assistant
Panel	Accepting New Members - other departments may frequently say "Panel" instead, both are correct
PAR	Participating Provider
PCP	Primary Care Provider
PHI	Protected Health Information
PHO	Physician Hospital Organization
PMPM	Per Member, Per Month or Per-Member, Per-Month
POS	Place of Service for claim pends
PPO	Preferred Provider Organization
PRTF	Psychiatric Residential Treatment Facility
RHC	Rural Health Clinic
QA	Quality Assurance

SNF ("sniff")	Skilled Nursing Facility - in conversation you may here mention made of a "sniff" contract, this is referring to a Skilled Nursing Facility contract
SQL ("seek-wool")	Structured Query Language – a useful tool used to run reports and look-up data
TANF	Temporary Assistance for Needy Families
TAT	Turnaround Time
TIN	Tax Identification Number – 9-digit number assigned to Sole Proprietor Physicians and Groups
TPA	Third-Party Administrator
UM	Utilization Management
UB-04	Billing claim form used typically to bill facility claims



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