<table>
<thead>
<tr>
<th><strong>Important phone numbers</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td><strong>1-855-300-5528</strong></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td><strong>1-888-604-6106</strong></td>
</tr>
<tr>
<td>Provider Relations</td>
<td><strong>1-855-454-0061</strong></td>
</tr>
</tbody>
</table>
| Prior Authorization Medical | Phone **1-888-725-4969**  
Fax **1-855-454-5579**  
Behavioral Health  
Phone **1-888-604-6106**  
Fax **1-855-301-1564**  
Pharmacy  
Phone **1-855-300-5528**  
Fax **1-855-799-2550**  |
| 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/Triad) | **1-888-584-8742** |
| Reporting Fraud & Abuse     | **1-855-300-5528** |
| Pharmacy                    | **1-855-300-5528** |
| **Additional Information** |  |
| Office location             | AetnaBetterHealth of Kentucky  
9900 Corporate Campus Drive Suite 1000  
Louisville, KY 40223 |
| Claims information          | EDI Payor ID (Claim) #128KY  
P O Box 65195  
Phoenix, AZ 85082-5195 |
| Member eligibility verification | **1-855-300-5528** |
| Member Eligibility verification at KYHealthChoices.net | **https://public.kyommis.com** |
| Case and Disease Management Referrals | **1-888-470-0550** |
| Returned checks and refunds  | Aetna Better Health of Kentucky – Finance  
4500 E. Cotton Center Blvd  
Phoenix, AZ 85040 |
| Complaints appeals address   | Aetna Better Health of Kentucky  
Attn: Appeals Department  
9900 Corporate Campus Drive  
Suite 1000  
Louisville, KY 40223  
FAX: **1-855-454-5585** |
| Website                     | **www.aetnabetterhealth.com/kentucky** |
| Provider portal             | **http://aetnabetterhealth-kentucky.aetna.com** |
Table of Contents

Section 1 - Introduction

Welcome ..................................................................................................................... 12
About Us .................................................................................................................. 12
Model of Care ......................................................................................................... 12
Service area ............................................................................................................ 13
About this provider manual ..................................................................................... 13
Disclaimer ............................................................................................................... 13
Contacts .................................................................................................................. 14
Website ................................................................................................................... 15
Provider portal ........................................................................................................ 15
Secure online portal ................................................................................................ 16
Overview of features for members ........................................................................ 16
Vendor contacts ....................................................................................................... 17
Requirements for Participation ............................................................................... 17
Medical record documentation standards ............................................................. 19

Section 2 - Provider Relations Department ............................................................ 22

Provider relations ................................................................................................ 22
Provider relations mission statement .................................................................... 22
Top 10 reasons to contact your provider relations representative ....................... 22
New Provider Orientation ...................................................................................... 23
Participating providers .......................................................................................... 23
Provider selection standards ................................................................................ 23
Credentialing process and application requirements ............................................. 24
Facility site review ................................................................................................. 25
Application Requirements for Ancillary/Facility Providers ................................... 25
Re-Credentialing requirements ............................................................................. 25
Primary care providers (PCP) ............................................................................... 26
Responsibilities of primary care providers ........................................................... 26
PCP panel listing ..................................................................................................... 27
Vaccines for children program .............................................................................. 28
Lock-in program .................................................................................................... 28
Encounter data/claim submission requirement .................................................... 29
Specialty care providers ....................................................................................... 29
Section 3 - Preventive Care Services ................................................................. 37

Adult health screening ............................................................................. 37
Early Periodic Screening Diagnosis Treatment (EPSDT) ......................... 38
Who provides EPSDT? ............................................................................ 39
What happens when abnormalities are identified? .................................... 39
Who are members referred to? ................................................................. 39
Components of a full medical screen ....................................................... 40
Interval history/parent’s concerns/child’s concerns ................................. 40
Nutritional assessment ........................................................................... 40

Responsibilities of the specialty care provider ............................................. 29
Hospital providers .................................................................................. 30
Responsibilities of the hospital provider .................................................... 30
Ancillary providers .................................................................................. 31
Responsibilities of the ancillary provider ................................................... 31
Provider access guidelines ....................................................................... 31
Scheduling appointments and waiting times .............................................. 31
Waiting times ......................................................................................... 32
Missed appointments/follow-up visit ....................................................... 32
Twenty-four (24) hour access to care ...................................................... 33
Management of after-hours access to services ......................................... 33
Authorizations of after-hours services ...................................................... 33
PCP capacity monitoring ........................................................................ 34
Other provider concerns ......................................................................... 34
Communications with members ............................................................... 34
Medicaid provider preventable condition claim denial and reporting process .................................................. 34
Primary care panel changes ..................................................................... 34
Panel closings ......................................................................................... 34
PCP panel limit ....................................................................................... 34
Subcontracting services ........................................................................... 34
Termination by Aetna Better Health of Kentucky .......................................... 35
Member notification of provider terminations .......................................... 35
Continuation of care after termination ..................................................... 35
Transfer of information between providers .............................................. 35
Primary care providers ........................................................................... 35
Specialty care providers ......................................................................... 36
Behavioral health care providers ............................................................. 36
Unclothed physical examination
Anticipatory guidance
Lab/immunizations
Lead screening & testing
Development personal-social and language
Fine motor/gross motor
Hearing
Vision
Dental
EPSDT billing and reporting
Care management and support available from Aetna Better Health of Kentucky
Section 4 - Member Services and Benefits
Member Services Department
Member Eligibility Verification Options
Member identification (ID) Card
Sample member ID card
Member rights and responsibilities
Kentucky Medicaid plan member rights
Members have the responsibility:
Member enrollment and PCP assignment
Member enrollment into Aetna Better Health
Newborn enrollment
PCP assignment process
Procedure for members to change PCP
Member disenrollment from PCP panel
Member disenrollment from Aetna Better Health of Kentucky
Member literature and publications
Member handbook
Member newsletters
Member education
New member packet
Member outreach program
Aetna Better Health of Kentucky provider marketing guidelines
Member co-payments
Benefit determinations
Medical services
Section 5 - Medical Management

Utilization Management (UM) Program
Purpose
Program oversight
Utilization Management staff
Appropriate utilization of care without conflict of interest nor incentives
Prior authorization, concurrent review and retrospective review criteria
Communication with members regarding treatment
Medically necessary
Requesting authorization
Medical necessity decisions
Peer-to-peer reviews
Decision and notification standards
Notice of action
Authorization confirmation
Authorization confirmation via provider portal
Authorizations and claim submission
Pre-admission review
Section 6 - Vision Service

Vision services

Claim submission for vision services
Section 7 - Pharmacy

Pharmacy services.................................................................................................................. 75
Pharmacy benefit manager................................................................................................. 75
Prescribing practitioners..................................................................................................... 75
Pharmacy and medication management............................................................................. 75
Pharmacy network.............................................................................................................. 76
Covered drugs and services............................................................................................... 76
Mandatory generics............................................................................................................. 76
Step therapy......................................................................................................................... 77
Quantity limits..................................................................................................................... 77
Formulary............................................................................................................................... 77
Pharmacy help desk........................................................................................................... 77
Self-administered injectable medications......................................................................... 77
Non-covered drugs............................................................................................................. 77
Copays................................................................................................................................. 78

Section 8 - Quality Improvement

Executive Quality Improvement Committee (EQIC) ......................................................... 79
Quality Management/Utilization Management (QM/UM) Committee ......................... 79
Goals and Objectives......................................................................................................... 80
Scope of Quality Improvement Program........................................................................ 81
Clinical Practice Guidelines.............................................................................................. 82
Provider participation........................................................................................................ 83
Medical record management............................................................................................ 83
Copy or access to member medical records..................................................................... 84
Confidentiality...................................................................................................................... 84
Release of information....................................................................................................... 84
Storage................................................................................................................................. 84
Transfer of medical records.............................................................................................. 84
Medical records retention................................................................................................. 84
Provider on-going monitoring.......................................................................................... 85
Continuous monitoring for quality of care and service by providers............................. 85
Cultural competence......................................................................................................... 86
Meeting member’s cultural and linguistic needs............................................................... 87
Section 9 - Claims and Reimbursement Procedures

Claim forms (CMS and UB) ......................................................... 97
General Claims Information and Requirements ........................................ 97
Ordering, referring, and prescribing requirements ........................................ 99
Claim payments and processing timeframes ........................................ 100
Claim coding ........................................................................ 100
Components of a “clean” claim .......................................................... 100
Authorization and claim submission .................................................... 100
Claim submission address for paper claims ........................................ 101
National Provider Identifier (NPI) Number and Taxonomy ......................... 101
Electronic Claim Submission (EDI) ....................................................... 102
Electronic Submission of Corrected Claims ............................................... 102
Proof of timely filing ................................................................ 102
Electronic Funds Transfer (EFT) ............................................................ 104
Electronic Remittance Advice (ERA) ....................................................... 104
Remittance advice .................................................................. 104
Claims inquiry claims research (CICR) ................................................... 105
Claim specific requirements .............................................................. 105
Anesthesia start/stop times ............................................................... 105
Assistant surgeon .................................................................. 105
Bilateral procedures ................................................................ 105
Modifier – EP (EPSDT Services) ............................................................. 106
Immunizations ..................................................................... 106
Submission of itemized billing statements ............................................... 106
Legal Owner of Tax Identification Number (TIN) .................................................................................. 106
Clinical Claims Editing .................................................................................................................. 106
Balance billing/hold harmless ......................................................................................................... 108
Completion of special reports or forms for members ........................................................................ 109
Access to records .......................................................................................................................... 109
Pediatric sexual abuse examination ................................................................................................. 109
Collection advice/remittance .......................................................................................................... 109
Recoveries ........................................................................................................................................ 109
Section 10 - Complaint Process for Providers and Members ........................................................ 111
  Provider complaint and appeal process ......................................................................................... 111
  Provider complaints .................................................................................................................... 112
  Member complaints .................................................................................................................... 112
  Provider appeal process ............................................................................................................. 113
  Member appeals ....................................................................................................................... 115
  Expedited appeals ..................................................................................................................... 115
  State fair hearing ...................................................................................................................... 116
  Member inquiry ....................................................................................................................... 116
  Claim reviews ........................................................................................................................... 116
  Process definitions and timeframes ............................................................................................ 117
Section 11 - Fraud and Abuse Guidelines .................................................................................... 119
  Kentucky Medicaid managed care fraud definition .................................................................... 119
  Kentucky Medicaid managed care abuse definition .................................................................. 119
  Program description .................................................................................................................. 119
  Federal deficit reduction Act of 2005 (DRA) ............................................................................. 119
  How to report fraud and/or abuse ............................................................................................ 120
Section 12 - HIPAA ......................................................................................................................... 121
  HIPAA ......................................................................................................................................... 121
  Privacy rule .............................................................................................................................. 121
  Protected health information (PHI) ............................................................................................... 121
  Delegated Credentialing, Utilization Management and Quality Improvement Activities .............. 121
  and Protected Health Information (PHI) ................................................................................... 121
  Contacting Aetna Better Health of Kentucky by phone ............................................................... 123
  Emailing protected health information ....................................................................................... 123
  Personal representative .............................................................................................................. 123
  Member designated individuals .................................................................................................. 123
  Claims inquiries ....................................................................................................................... 123
Provider complaints and appeals ............................................................. 123
Audits of member’s medical records ...................................................... 123
EDI transactions .................................................................................. 124
Code sets ............................................................................................. 124
Disposition of PHI at termination .......................................................... 124
Section 13 - State and federal programs Requirements and services ............. 125
  Communicable disease reporting .......................................................... 125
  Physician incentive program (PIP) regulations ...................................... 125
  Overview of the provider incentive program (PIP) regulation ................ 125
  To whom does this section apply? ......................................................... 125
  What information is required to be disclosed/reported? ......................... 125
  How can providers and subcontractors cooperate with Aetna Better Health? 126
  What payments are prohibited? ............................................................. 126
  What information must be reported to CMS and the Cabinet by Aetna Better Health? 126
  What information must be reported to Aetna Better Health members? .... 127
  What is Substantial Financial Risk (SFR)? ........................................... 127
  What happens when substantial financial risk exists? ........................... 127
  What happens if an MCO or a provider does not comply with PIP requirements? 127
SECTION 1 - INTRODUCTION

WELCOME

Aetna Better Health of Kentucky is 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 all our providers’ efforts in helping us achieve that goal.

In order to ensure that Aetna Better Health of Kentucky communicates effectively with providers, we have developed this Provider Manual to assist our providers. This document is designed to guide you through Aetna Better Health of Kentucky’s administrative processes. We will continue to supply our providers with updates via letters, fax blast*, the provider website, newsletters and contact with provider relations representatives as changes occur.

* If you are not currently receiving fax blast from Aetna Better Health and would like to, be sure to contact your Provider Relations Representative to update your fax number in your file.

Thank you for your participation and interest in caring for our members.

ABOUT US

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and we currently serve more than 2 million people in 15 states. Aetna Medicaid and our affiliates currently own and administer Medicaid services in Arizona, California, Florida, Illinois, Louisiana, Kentucky, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia and West Virginia.

Aetna Medicaid has 30 years’ experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

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 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.

**SERVICE AREA**

See the Aetna Better Health of Kentucky service area map below. We serve all 120 counties in Kentucky.

![Service Area Map](image)

**ABOUT THIS PROVIDER MANUAL**

This provider handbook serves as a resource to our providers and outlines operations for Aetna Better Health of Kentucky. Through the provider handbook, you will find answers to common questions you may have regarding Aetna Better Health of Kentucky. Questions, problems, or concerns that the provider handbook does not fully address can be directed to our Provider Services department at 1-855-300-5528. You can also contact your Provider Relations Representative. A list of provider relations representatives can be found on our website at [www.aetnabetterhealth.com/kentucky/providers/library](http://www.aetnabetterhealth.com/kentucky/providers/library).

**DISCLAIMER**

Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health of Kentucky, and with an Aetna Better Health provider agreement, including requirements described in this manual, in addition to all federal and state regulations governing a provider. While this manual contains basic information about Aetna Better Health, the Kentucky Department of Medicaid Services (DMS) and the Cabinet for Health and Family Services (CHFS), providers are required to fully understand and apply DMS and CHFS requirements when administering covered services. Please refer to [http://chfs.ky.gov](http://chfs.ky.gov) for further information on CHFS.
## CONTACTS

Aetna Better Health of Kentucky’s standard contacts are listed below:

<table>
<thead>
<tr>
<th>Aetna Better Health contacts</th>
<th>Toll-free</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>1-855-300-5528</td>
<td></td>
</tr>
<tr>
<td>Member Services</td>
<td>1-855-300-5528</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1-855-300-5528</td>
<td>1-855-799-2550</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1-888-604-6106</td>
<td>1-855-301-1564</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>1-888-470-0550, #4, #3, #7</td>
<td>1-855-336-6054</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>1-888-470-0550, #4, #3, #6</td>
<td>1-855-454-5043</td>
</tr>
<tr>
<td>Prior Authorization – Medical</td>
<td>1-888-725-4969</td>
<td>1-855-454-5579</td>
</tr>
<tr>
<td>Prior Authorization – Behavioral Health</td>
<td>1-888-604-6106</td>
<td>1-855-301-1564</td>
</tr>
<tr>
<td>Prior Authorization - Pharmacy</td>
<td>1-855-300-5528</td>
<td>1-855-799-2550</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-855-454-0061</td>
<td>1-855-454-5584</td>
</tr>
<tr>
<td>Appeals</td>
<td>1-855-300-5528</td>
<td>1-855-454-5585</td>
</tr>
<tr>
<td>Care/Disease Management</td>
<td>1-888-470-0550</td>
<td>1-855-454-5044</td>
</tr>
<tr>
<td>Lock-In Program</td>
<td>1-855-300-5528</td>
<td>1-866-415-2818</td>
</tr>
</tbody>
</table>

The Aetna Better Health of Kentucky office is closed on these federal holidays:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

### Important addresses

**Claims**

Electronic Payor ID: 128KY

Mailing address:

Aetna Better Health of Kentucky

P.O. Box 65195

Phoenix, AZ 85082-5195

**Appeals**

Aetna Better Health of Kentucky

Attn: Appeals Department

9900 Corporate Campus Drive, Suite 1000

Louisville, KY 40223

**Provider relations**

Aetna Better Health of Kentucky

Attn: Provider relations

9900 Corporate Campus Drive, Suite 1000

Louisville, KY 40223
WEBSITE

Within our website, a secure provider web portal is maintained; the web portal can be accessed directly at aetnabetterhealth-kentucky.aetna.com. Our secure provider web portal provides a platform for Aetna Better Health of Kentucky to communicate health care information directly to you. Our health plan’s eligibility and claims information can be accessed via the web portal.

In addition to our telephone numbers above, participating providers may access our website 24 hours a day, 7 days a week at: www.aetnabetterhealth.com/kentucky for up-to-date information, forms and other resources. If you haven’t yet registered for the portal, please complete the portal registration form (www.aetnabetterhealth.com/kentucky/providers/portal) and return via fax or email to your Provider Relations Representative for processing.

PROVIDER PORTAL

Aetna Better Health of Kentucky offers a secure provider website that directly connects providers with real-time information that is absolutely FREE. As an alternative to the various channels providers can use today, our aetnabetterhealth-kentucky.aetna.com site provides a one-stop, self-service tool, offering our providers a direct connection. Our site was built off our knowledge as well as feedback from providers to build a website that is easy-to-use and contains the tools and information providers need to get their job done. By directly connecting to our organization through aetnabetterhealth-kentucky.aetna.com, providers realize a better response for payments, a simplified work flow process, and content and tools that address the needs of all providers, regardless of size.

Available features:

- Claims status check including history about receipt, processing and adjudication
- Member eligibility, status check including PCP history, batch eligibility
- Viewable remittance advices, including EFT information
- Authorization view
- Resource library, including technology assessments and medical criteria
- HEDIS® Reports
- Member ID card (view and print) primary insurance information

In addition, our website and the provider portal contain downloadable forms, including the Provider Manual and provider newsletters/bulletins.
You may complete the registration process for our provider portal by accessing the forms available on our website, www.aetnabetterhealth.com\kentucky, go to “For Providers” and then click on “Document Library”.

**SECURE ONLINE PORTAL**

Aetna Better Health of Kentucky is dedicated to providing great service to our providers and our members. That's why our HIPAA-compliant web portal is available 24 hours a day. The portal supports the functions and access to information related to:

- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- Member and provider education and outreach materials

If you’re interested in using this secure online tool, you can register on our “For Providers” page at www.aetnabetterhealth.com\Kentucky. You can also contact our Provider Services department to sign up over the phone. Or to submit your registration via fax, you can download the form from our website or request a copy from Provider Services. And keep in mind that internet access with a valid e-mail is required for registration.

Remember, provider groups must first register a principal user known as the "Provider-Admin." Once registered, the “Provider-Admin” can add authorized users within each entity or practice.

**OVERVIEW OF FEATURES FOR MEMBERS**

At aetnabetterhealth-kentucky.aetna.com, 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 are able to access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status – Members and their providers 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, request a refill for mail-order medications and find an in-network pharmacy by zip code. They can also figure out drug interactions, side effects and risk for medications and get 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 referral and information on authorization requirements. And they can find benefit and financial responsibility information for a specific service.
- Innovative services information – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
• Health information Line – The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.

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

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at aetnabetterhealth-kentucky.aetna.com. Or they can call Member Services at 1-855-300-5528.

VENDOR CONTACTS

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avesis (vision)</td>
<td>1-855-214-6776</td>
</tr>
<tr>
<td>Avesis (dental)</td>
<td>1-855-214-6776</td>
</tr>
<tr>
<td>Change Healthcare</td>
<td>1-877-469-3263</td>
</tr>
<tr>
<td>eviCore (radiology)</td>
<td>1-888-693-3211</td>
</tr>
<tr>
<td>CVS (pharmacy)</td>
<td>1-855-300-5528</td>
</tr>
<tr>
<td>eviCore/Triad (pain management)</td>
<td>1-888-693-3211</td>
</tr>
<tr>
<td>Reporting Fraud and Abuse</td>
<td>1-855-300-5528</td>
</tr>
</tbody>
</table>

REQUIREMENTS FOR PARTICIPATION

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 provide 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 are required to complete three distinct requirements to become participating providers with Aetna Better Health:
  o Complete a participating agreement with Aetna Better Health of Kentucky
  o Submit all necessary credentialing information
  o Submit the Kentucky MAP-811 (Kentucky Medicaid enrollment application) or Kentucky Medicaid Provider Number.

• 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, receipt of health care, 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 that 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 Section 8. 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 Section 4 - 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, and 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 provider relations representative at any time if they require further details on requirements for participation.

**MEDICAL RECORD DOCUMENTATION STANDARDS**

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

• Organized medical record maintained separately for each member.

• 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.

• Record legibility to someone other than the author. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

• All entries and encounters should be 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 – Appropriate subjective (chief complaints or purpose of visit) findings are documented and should include the history of current illness. Appropriate objective findings (physical exam) are documented and related to complaints or purpose of visit.

• Diagnosis or Assessment – A diagnosis, working diagnosis, or medical impression must be documented related to the findings.

• Plan of action/treatment – Plan of action/treatment documented is consistent with the diagnosis/impression, and includes consultations, therapies, and prescribed regimens.

• Problem list -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.

• Medication List – The medication list records past and current medications, should be reviewed with each patient encounter, and include the provider’s initials and date indicating review of the medication list.

• Follow-up visits – Unresolved problems from previous office visits should be addressed in subsequent visits.

• Emergency Care – When a member is treated at an emergency department, there should be a note acknowledging the visit (and the follow-up care if indicated).

• Return Visit – 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).

• Consultation Reports – 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, ancillary services – Labs, X-rays, imaging reports and other referrals or 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 – 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.

• Immunization record – 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 federal regulations or Kentucky Administrative Regulation (KAR). 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.
SECTION 2 - PROVIDER RELATIONS DEPARTMENT

PROVIDER RELATIONS
Aetna Better Health maintains a strong commitment to meeting the needs of our providers. In order to accomplish this, a provider relations representative is assigned to all our participating providers. This process allows each practice to become familiar with its representative and form a solid working relationship.

Your provider relations representative will visit or phone you to ensure that your day-to-day experience with Aetna Better Health and our members is smooth. We are available to meet with office staff or providers upon your request. Various training seminars are held throughout the year. Provider communications are sent to our providers along with specialized mailings that include updates to our provider manual, changes in policy, benefits, and general news and information of interest to our provider community. These communications are routinely sent via facsimile transmission. Please ensure that our provider relations department has your current fax number so you will receive Aetna Better Health provider communications. You may also access information on our website at www.aetnabetterhealth.com/kentucky or our provider portal at aetnabetterhealth-kentucky.aetna.com.

Copies of previous provider communications are available at www.aetnabetterhealth.com/kentucky on the “For Provider” tab. Our provider relations department is responsible for the field service and ongoing education and training of our provider community. Please refer to the “Who is Your Provider Representative” handout on our website or provider portal to find your provider relations representative. Simply visit www.aetnabetterhealth.com/kentucky/providers/library to access the document “Who is my Provider Relations Representative?”, or call the Provider Relations department at 1-855-454-0061.

PROVIDER RELATIONS MISSION STATEMENT
Our provider relations department and provider relations representatives pledge to provide superior customer service to our providers. We will:

- Develop strong relationships with providers, staff and community.
- Proactively communicate accurate information in a timely manner in order to assist our providers in delivering high quality health care to our members.
- Be a reliable resource to support and assist providers in the smooth operation of their practice.
- Provide excellent service to both our internal and external customers.
- Commit to be leaders of positive change and to Aetna Better Health being known as the best managed care organization.
- Involve all Aetna Better Health employees to provide excellent provider service.

TOP 10 REASONS TO CONTACT YOUR PROVIDER RELATIONS REPRESENTATIVE
1. Any change to your practice (i.e., practice tax ID, name, phone numbers, fax numbers, address, addition/termination of providers or member acceptance). Please use the Provider Notification Form found in the document library on the Aetna Better Health of Kentucky website at www.aetnabetterhealth.com/kentucky, Provider tab to Document Library under Forms, or submit notice in writing.
2. Initiate credentialing of new providers
3. Schedule an in-service for new staff
4. Sign up for our provider portal
5. Clarification of Aetna Better Health policies and procedures

6. Order materials such as our provider manual and authorization guidelines. Clarification of participating provider contract

7. Request fee schedule information

8. Membership list questions

And the biggest reason -

9. E-Business. Find out how to use electronic solutions to submit authorizations, check eligibility and/or claims status at your convenience, sign up for electronic fund transfers (EFT), electronic remittance advice (ERA), and our portal at aetnabetterhealth-kentucky.aetna.com.

NEW PROVIDER ORIENTATION

Upon credentialing approval by Aetna Better Health, a welcome letter for new contracts, along with an approval letter that confirms credentialing, is sent to your practice. Within 30 days of your effective date, one of our provider relations representatives will contact your office in person, by mail or by telephone to schedule an orientation.

Our Aetna Better Health provider relations representative will furnish your office with all applicable new provider information regarding provider rights and responsibilities as an Aetna Better Health provider.

Our provider relations representative will take notes during the orientation to identify any issues that can't be resolved during the orientation. The representative will research and resolve any outstanding issues identified during the orientation visit in a timely manner.

In addition, if you’d like a refresher orientation, or if you have new staff members and would like another orientation, please contact your provider relations representative to schedule a visit.

PARTICIPATING PROVIDERS

Please visit our provider search option on our website at www.aetnabetterhealth.com/kentucky or contact your provider relations representative for a participating provider listing or any updates. Our online provider directory is updated weekly. If you have questions about information in the online directory, please contact your provider relations representative.

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.

- Provider holds a valid Kentucky Medicaid Identification Number.

- 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 Federal Drug Enforcement Agency (DEA) registration, if applicable.
• 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.

CREDENTIALING PROCESS AND APPLICATION REQUIREMENTS

Application requirements for primary care and specialty care providers:

• 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:
    o The ability to perform the essential functions of the positions, with or without accommodation
    o Lack of present illegal drug use
    o History of loss of license and felony convictions
    o History of loss or limitation of privileges or disciplinary activity
    o Sanctions, suspensions or terminations imposed by Medicare or Medicaid
    o 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.

**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.

**Application Requirements for Ancillary/Facility Providers**
Requests for an ancillary/facility application should be directed to our provider relations department. The applicant must provide a completed, signed and dated ancillary/facility application to us to properly verify your qualifications. Ancillary provider sites may require a facility review if they don’t hold an acceptable accreditation. In addition to the ancillary/facility application, the following items must be provided:

- Signed Participating Provider Agreement
- List of licensed services offered
- Copy of current state medical license
- Copy of professional liability insurance (face sheet)
- Copy of accreditation certificate(s)
- Copy of accreditation organization’s letter indicating accreditation level
- Copy of CMS certificate or state audit report
- Copy of full CMS audit report
- Copy of completed IRS W-9 form
- Complete listing of service area, including cities and counties
- Completed and signed MAP-811 (Kentucky Provider Application) form for new ancillaries or facilities for Medicaid ONLY

**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 credentialing/re-credentialing file. 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. This information includes, but isn’t limited to, credentialing information needed to support credentialing related audits.
PRIMARY CARE PROVIDERS (PCP)

RESPONSIBILITIES OF PRIMARY CARE PROVIDERS

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 has 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 OB/GYN practice;
- Physician assistants;
- Primary care clinics; and,
- Physicians with a specialty in family and general practice, pediatrics, OB/GYN and internal medicine.
- Aetna Better Health makes available primary care teams and clinics to serve as primary care providers. The primary care team and clinic must provide the range of services required of all primary care providers. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.
- 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 KYHealth-Net at https://public.kymmis.com. Please contact Aetna Better Health Customer Service at 1-855-300-5528, if assistance is needed.
- PCPs must be functioning within the scope of their licensure, with hospital admitting privileges or a formal referral agreement with a provider possessing admitting privileges that provides primary health care services 24 hours a day, 7 days a week.
- Verify member’s status as a Lock-In member and determine the providers to which a member is restricted for services.
- Provide, coordinate and/or direct all health care needs of members to maintain continuity of care.
- Perform, track, and report Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screenings, exams and/or treatment for all pediatric members.
- 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 a behavioral health screening to determine whether the member needs behavioral health services.

• 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.

• Follow the requirements of the utilization management program, quality management program and other policies and procedures set forth in the Provider Manual.

• Provide and/or coordinate 24-hour accessibility for members.

• Communicate information to each member regarding the right to institute an advance directive.

• Maintain a comprehensive and legible medical record including documentation of all services provided to the member by the PCP, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.

• Provide all of the health care services and supplies that are medically necessary, generally available by the provider that the provider is licensed to provide, and are covered under the terms of the applicable benefit plan.

• Adhere to provider access and availability guidelines.

• Participating providers may not discriminate against Kentucky Medicaid Managed Care members or treat them differently than others patients receiving services from said provider.

• 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.

**PCP PANEL LISTING**

PCPs may receive a listing of members assigned to their panel, upon request to the provider’s assigned provider relations representative. PCPs must verify eligibility for Aetna Better Health members at each date of service or encounter. Providers should use KYHealth-Net at [https://public/kymmis.com](https://public/kymmis.com) to verify eligibility. Please contact Aetna Better Health Customer Service at 1-855-300-5528, if assistance is needed. Providers should also determine if a member is enrolled in the Lock-In Program to determine the providers to which the member is allowed to use. Treatment of a Lock-In member for non-emergency services by a provider who does not serve as the member’s medical home may not be reimbursed by Aetna Better Health.

The panel listing should be reviewed and PCPs should attempt to contact new members to schedule a visit to establish a relationship with the assigned member. PCPs are responsible for providing all primary care services for members listed on the panel.
VACCINES FOR CHILDREN PROGRAM
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 is confirmed by accessing KYHealth-Net 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.

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 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)
2. Pharmacy
3. Emergency department

A designated primary care provider must meet the following requirements:

A. Must meet the normal time and distance access standards. See Page 19 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 provider website, under documents 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 providing a service, providers should determine whether a member is in the 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 restricted provider may not be reimbursed by Aetna Better Health.

ENCOUNTER DATA/CLAIM SUBMISSION REQUIREMENT

Aetna Better Health is mandated by our contract with CHFS to report all provider encounters. We require claims and encounter data to be submitted using a Uniform Billing (UB) or CMS form, even if the provider is paid on a capitated basis. Claims must be received within 365 days from the date of service for office level/outpatient services or from the date of discharge for hospitalization services. Corrected claims must be received within 24 months from the initial remittance advice date. It is not necessary for corrected claims to include all original claim lines, including those previously paid correctly. CHFS requires a provider have a valid Kentucky Medicaid ID number to submit an encounter/claim to Aetna Better Health of Kentucky. Claims/encounters submitted without a valid Kentucky Medicaid ID number will be rejected. Provider must bill with NPI and Taxonomy coding and should include A210 provider validation expectations.

SPECIALTY CARE PROVIDERS

RESPONSIBILITIES OF THE SPECIALTY CARE PROVIDER

The following is an overview of the responsibilities specialty care providers assume when providing care to Aetna Better Health members:

- Verify member eligibility at every visit or encounter prior to rendering services by accessing KYHealth-Net at [https://public.kymmis.com](https://public.kymmis.com). Please contact Aetna Better Health Customer Service at 1-855-300-5528, if assistance is needed.

- Follow our prior authorization guidelines when directing members to receive diagnostic, home care, hospitalization, outpatient or additional consultation services.

- Communicate in writing with the PCP to ensure continuity of health services for ongoing treatment. Mail or fax all summaries, evaluations or recommendations within two (2) weeks from the date of service.

- Coordinate with the PCP the need for additional medical treatment identified during well-woman exams.

- Maintain a comprehensive and legible medical record.

- Adhere to provider access and availability guidelines for scheduling appointments and waiting times.

- Provide all of the health care services and supplies that are medically necessary, that are generally available at 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.
• Provider agrees to 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 or provide treatment differently from other persons receiving services.

• Prior to providing a service, specialty providers should determine if a member is enrolled in the Lock-In Program to determine the providers to which the member is restricted. A specialty provider must have a current referral from the member’s Lock-In PCP to provide a service to a Lock-In member. Treatment of a Lock-In member for non-emergency services by a provider who does not serve as the member’s medical home or for which a specialist does not have a referral may not be reimbursed by Aetna Better Health.

HOSPITAL PROVIDERS

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.

• 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.

• Follow the Aetna Better Health authorization guidelines.

• 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 or directing provider 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 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.

ANCILLARY PROVIDERS

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 KYHealth-Net at https://public.kymmis.com. Please contact Aetna Better Health Customer Service at 1-855-300-5528, if assistance is needed.

• Follow the Aetna Better Health authorization guidelines.

• Promote access to quality care by directing members to use Aetna Better Health network providers.

• Coordinate with the member’s PCP or directing provider 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.

• Provider agrees to 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.

PROVIDER ACCESS GUIDELINES

SCHEDULING APPOINTMENTS AND WAITING TIMES
The following access and availability standards must be provided by all our participating providers:

<table>
<thead>
<tr>
<th>Medical services</th>
<th>Access/appointment standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment type</td>
<td>Access/appointment standard</td>
</tr>
<tr>
<td>Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent care appointments</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Non-urgent sick appointments</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Initial new member appointment</td>
<td>Less than 12 weeks</td>
</tr>
<tr>
<td>Routine and preventative care</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Maternity care</td>
<td>Access/appointment standard</td>
</tr>
<tr>
<td>Appointment type</td>
<td>Access/appointment standard</td>
</tr>
<tr>
<td>Initial prenatal visit for newly enrolled pregnant</td>
<td>Within 14 days</td>
</tr>
</tbody>
</table>
### Behavioral Health & Substance Use Services

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access/Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Within 6 hours for non-life threatening emergency services</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>New member appointments</td>
<td>Within 10 days</td>
</tr>
<tr>
<td>Aftercare appointments</td>
<td>Within 7 days after hospital discharge</td>
</tr>
<tr>
<td>Other referrals</td>
<td>Within 60 days</td>
</tr>
</tbody>
</table>

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 with 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 10 days. Adolescents in particular shall be assured that family planning services are confidential and that any necessary follow-up will assure the member’s privacy.

### 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 log books or sign-in sheets must be maintained by providers to demonstrate compliance with this requirement.

(Except: 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 Visit

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.

Provider relations randomly select and survey providers after their normal business hours to monitor compliance. Providers who do not meet the criteria for after-hours access will be contacted by provider 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.

**Note:** Aetna Better Health does not accept automatic referrals of members to hospital emergency rooms or urgent care centers as acceptable after-hours coverage arrangements.
PCP CAPACITY MONITORING
Aetna Better Health has established the following member to primary care provider standard in order to measure provider capacity for its provider network and ensure adequate network capacity of primary care providers by region.

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Member to PCP capacity standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care providers</td>
<td>1500: 1 = 1500 members to 1 practitioner</td>
</tr>
</tbody>
</table>

OTHER PROVIDER CONCERNS

COMMUNICATIONS WITH MEMBERS
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.

PRIMARY CARE PANEL CHANGES

PANEL CLOSINGS
Please note that if you close your panel to Aetna Better Health members, you must close your panel to all payors/members. All requests to close your panel must be submitted in writing to your provider relations representative with at least 60 days advance notice.

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 primary care 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. The contract with CHFS and Aetna Better Health states that no one practitioner shall have a panel with a ratio greater than 1500:1.

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.
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 there in.

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.

TRANSFER OF INFORMATION BETWEEN PROVIDERS

During the orientation process, the Aetna Better Health provider relations representatives will educate the provider and their office staff on the following to ensure continuity of care for our members:

PRIMARY CARE PROVIDERS

When a PCP refers a member to a specialist, the PCP will forward (at no cost to the plan or member), all appropriate notes, x-rays, reports or other medical records to the specialist, prior to the member’s scheduled appointment. If an Aetna Better Health member changes their PCP, the previous PCP will forward, at no cost to the plan or member, the member’s medical records within 10 days of request to the member’s new PCP.
**SPECIALTY CARE PROVIDERS**

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.

**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 members PCP, with the member’s or the member’s legal guardian’s consent.
SECTION 3 - PREVENTIVE CARE SERVICES

ADULT HEALTH SCREENING
The adult health screening assesses the health status of a Kentucky Medicaid recipient over age 20. It is to be used to detect and prevent disease, disability, and other health conditions or their progression. Providers administering this service must be able to coordinate the provisions of all required components. The recommended adult health screening schedule is below. Aetna Better Health will cover adult health screening consistent with the Preventative Health Guidelines which are available on the Aetna Better Health website at www.aetnabetterhealth.com/kentucky.

Components of adult health screenings

- Health history:
  - Present - current medicines, allergies, health behaviors, mental status
  - Past - immunizations, illness, transfusions or blood products, (intravenous) IV drug use, etc.
  - Family history
  - Risk factors - alcohol, drug use, tobacco use, sun exposure, radiation, sexual activity, occupational hazards, asbestos exposure, exposure to known carcinogens
  - Nutritional assessment - weight loss or gains, BMI measurement, consumption of meals, dietary habits

- Physical examination includes measurements of height, weight, blood pressure, pulse. Physical inspection includes general appearance, skin, eyes, ears, nose, throat, oral, thyroid, heart, lungs, abdomen, breasts, pelvic, testicular, rectal exam, prostate, and extremities.

- Visual acuity (E chart or Snellen chart)

- Hearing screen (Weber, Rinne or Puretone)

- Laboratory procedures include:
  - Urinalysis dipstick for blood, sugar and acetone
  - Hemoglobin and/or hematocrit
  - Stool for occult blood - as indicated, recommended for adults over 40
  - Tuberculin skin test - as indicated, recommended for adults over 40
  - Collection of cervical Pap smear recommended annually unless advised otherwise by a PCP
  - Collection of specimens for sexually transmitted diseases, as indicated

- Routine screening mammography is recommended for all females over age 35. Routine mammography is not recommended for men. Mammogram screening guidelines:
  - Age 40 to 50 years, one (1) screening mammogram every two (2) years
  - Age over 50 years, one (1) screening mammogram annually
  - Diagnostic mammography is performed when medically indicated.
  - Referral for treatment can be made when health problems or deficiencies are diagnosed. If abnormal test results are obtained, make a referral from the screening, when necessary.


EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (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.

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.

Components of a full EPSDT screen include the following:

- 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 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)

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 with regard to 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 screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99397) along with the EP modifier. An appropriate procedure code must be submitted on the CMS 1500 form. Please note: the Commonwealth of Kentucky typically does not allow EPSDT claims to be billed on a UB-04. Please contact your provider relations representative to determine if there are any exceptions for EPSDT special services.

The primary diagnosis should be submitted as the first diagnosis. Additionally, this same primary diagnosis must be reflected on the appropriate line item diagnosis pointer. 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 20 and under.

**WHO PROVIDES EPSDT?**

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.

**WHAT HAPPENS WHEN ABNORMALITIES ARE IDENTIFIED?**

The problem is treated and/or members are referred to providers, programs or agencies that are 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.

**WHO ARE MEMBERS REFERRED TO?**

- 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

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 of time.
- 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 [www.aetnabetterhealth.com/kentucky](http://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 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](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.

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 person for directly observed therapy. Aetna Better Health shall communicate with the local public health agency’s tuberculosis contact person 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.
- Analysis of the hemoglobin/hematocrit, urinalysis and TB skin test are included in the all-inclusive fee for screening.
LEAD SCREENING & TESTING
All children should have a 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 10–15 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

**EPSDT BILLING AND REPORTING**
Providers must submit Preventative Medicine CPT Codes (99381-99395) according to Commonwealth of Kentucky Provider Billing Instructions. 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 (field 24 E). In most instances, the primary diagnosis will be V20.2. Please refer to the billing instructions at [www.chfs.ky.gov](http://www.chfs.ky.gov). NOTE: EPSDT claims must be billed on a CMS 1500 form. The Commonwealth of Kentucky does not accept EPSDT claims billed on a UB-04.

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 20 and under.

**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
SECTION 4 - MEMBER SERVICES AND BENEFITS

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), your Aetna Better Health Provider ID number or your tax ID available for HIPAA verification purposes.

We will be closed on these federal holidays:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

MEMBER ELIGIBILITY VERIFICATION OPTIONS

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 encouraged to carry their Aetna Better Health Member ID card at all times. 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:

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

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

![Sample Member ID Card Image]
MEMBER RIGHTS AND RESPONSIBILITIES

KENTUCKY MEDICAID PLAN 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 Healthy 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.
MEMBERS HAVE THE 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.
- To actively participate in personal health and care decisions and practice 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 go to providers who take their Aetna Better Health of Kentucky member ID card.
- To show their Aetna Better Health of Kentucky and their Kentucky Medicaid 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 make sure that they only see Aetna Better Health of Kentucky providers.
- To keep all appointments and be on time.
- 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.
- Notify DCBS or SSA if they have a change like a birth, death, marriage or other insurance.
- To learn the difference between emergencies and urgent care.
- To understand their rights and responsibilities as a Kentucky Medicaid member.

MEMBER ENROLLMENT AND PCP ASSIGNMENT

MEMBER ENROLLMENT INTO AETNA BETTER HEALTH
The Cabinet is solely responsible for Kentucky Medicaid member enrollment. Once eligibility is verified through the Cabinet, the Kentucky Medicaid managed care eligible member must work with the Cabinet to select a managed care plan and select a PCP from that health plan’s PCP listing. The Cabinet then transmits a daily eligibility file to Aetna Better Health to notify of member additions, terminations and demographic changes. If a member does NOT select a PCP within 30 days from enrollment, Aetna Better Health Member Services will make a random PCP assignment on their behalf, based on availability and geographic location. If the member is dual eligible, presumptive eligible, a disabled child or a foster care child, the selection of a PCP is not required. For more information about CHFS Managed Care member enrollment process, please visit the CHFS website www.chfs.ky.gov.
NEWBORN ENROLLMENT

Most newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health by the Cabinet, 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 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 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 Claims Customer Service 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 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 provider relations representative 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.

PCP ASSIGNMENT PROCESS

Members are given the opportunity to select primary care providers (PCPs) when they enroll in the CHFS Medicaid Managed Care program. 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.

Members with disabling conditions and/or chronic illnesses may request a specialty care provider to act as their PCP. 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.

PROCEDURE FOR MEMBERS TO CHANGE PCP

Members may change their PCP, when eligible, by contacting Member Services at 1-855-300-5528. 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 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 PANEL**

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; or,
- 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 provider 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  
Provider Relations Department  
9900 Corporate Campus Drive, Suite 1000  
Louisville, KY 40223

Upon receipt of the request, the provider relations department 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 provider relations requesting the PCP auto assignment change for the member. The PCP change request will be sent to the Member Services for processing.

Once the PCP change has been 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 7–10 days. The member may call member services at 1-855-300-5528 during normal business hours to change the assigned PCP.

Once the new PCP has been selected, our provider relations department will contact the member’s previous and new PCP to facilitate the relationship including any assistance needed in transferring records from the previous PCP.

**MEMBER disenrollment from Aetna Better Health of Kentucky**

The Cabinet has sole authority to disenroll members. The Cabinet 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 LITERATURE AND PUBLICATIONS**

**MEMBER HANDBOOK**

The Aetna Better Health member handbook is written and designed in a member-friendly format. Major emphasis is placed on readability and understanding of benefits. Upon enrolling in Aetna Better Health, a member handbook is made available to all members. The handbook is also available on our website at www.aetnabetterhealth.com/kentucky.
**MEMBER NEWSLETTERS**

Aetna Better Health sends our members Bear Facts, a member newsletter, which emphasizes wellness and early intervention. Aetna Better Health also uses the Bear Facts newsletter to communicate CHFS-approved benefits and changes to members. The member newsletters are mailed directly to the member’s home address.

**MEMBER EDUCATION**

**NEW MEMBER PACKET**

Educational and informational materials are periodically sent to our members, including a new member packet upon enrollment. The packet contains the following:

- Welcome letter
- Aetna Better Health member ID card with the member’s PCP’s contact information
- Member handbook
- Provider directory
  - Information on how to request a provider directory and/or a member handbook containing member rights, responsibilities and benefits is available at [www.aetnabetterhealth.com/kentucky](http://www.aetnabetterhealth.com/kentucky) or by calling member services at 1-855-300-5528.

**MEMBER OUTREACH PROGRAM**

The Aetna Better Health member outreach program provides targeted education to members through regular mailings, newsletters, telephonically and the Aetna Better Health website. These outreach efforts include:

- Education and information on available benefits
- Reminders for annual well-child visits, EPSDT, lead testing, and immunizations
- Disease management for members with asthma, diabetes, depression, coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD)
- Birthday reminders highlighting important preventive health information
- Targeted care management outreach and education on applicable health topics for members who qualify

**AETNA BETTER HEALTH OF KENTUCKY PROVIDER MARKETING GUIDELINES**

Aetna Better Health and its participating providers are allowed to educate and conduct outreach campaigns to reach CHFS Medicaid eligible individuals; however, all activities are subject to CHFS guidelines.

Participating providers are required to submit all member marketing and education materials to Aetna Better Health prior to distribution to members. Aetna Better Health will submit all marketing and educational materials to CHFS on behalf of the participating providers for written approval. Providers may not use marketing and educational materials until written approval is given by Aetna Better Health of Kentucky. Approved member materials must contain the Aetna Better Health of Kentucky tracking number and approval number.
**Member Co-Payments**

Aetna Better Health may require co-pays or co-insurance for members for certain services. Please refer to the Benefit Schedules for the full list of specific co-pays/co-insurance amounts for members. Below is a list of the copays for 2017.

<table>
<thead>
<tr>
<th>Member benefit copays</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital Stays</td>
<td>$25</td>
</tr>
<tr>
<td>Including mental health and substance use services</td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$3</td>
</tr>
<tr>
<td>Emergency room, non-emergent use</td>
<td>$8</td>
</tr>
<tr>
<td>Prescription drugs, preferred brand</td>
<td>No copay</td>
</tr>
<tr>
<td>Prescription drugs, non-preferred</td>
<td>$4</td>
</tr>
</tbody>
</table>

**Benefit Determinations**

Aetna Better Health has established benefit plans for its members. Please refer to [www.aetnabetterhealth.com/kentucky](http://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**.

**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 [www.aetnabetterhealth.com/kentucky](http://www.aetnabetterhealth.com/kentucky) for a complete listing of network providers.

**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 [www.aetnabetterhealth.com/kentucky](http://www.aetnabetterhealth.com/kentucky) for a complete listing of contracted laboratories.

**Emergency Services**

Aetna Better Health will reimburse non-participating providers for emergency services rendered to treat an emergency medical condition according to Commonwealth guidelines, and in accordance with Section 6085 of the Deficit Reduction Act of 2005.

An emergency medical condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient 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
  – **Note:** Emergent services shall not be subject to prior authorization. Aetna Better Health must be notified within 1 calendar day, following an emergency admission, service or procedure.
• Aetna Better Health may contact members and providers that inappropriately seek routine and non-emergent services through emergency room visits to educate the member 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.

**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. Providers, members or other responsible parties may verify dental benefits by contacting Avesis’ Member Services at **1-855-214-6776**.

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.

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.

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

**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 **1-888-604-6106** 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 dependence 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.

**PHARMACY BENEFITS**

Please refer to Section 7 - Pharmacy of this provider manual for more information regarding pharmacy services.

**VISION/OPTICAL**

Please refer to Section 6 - Vision Service of this provider manual for more information regarding vision services.

**TRANSPORTATION SERVICES**

**NON-EMERGENCY MEDICAL TRANSPORTATION**

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](http://www.chfs.ky.gov). 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-EMERGENCY 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 transports 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.

**INTERPRETER SERVICES**

To promote the delivery of quality health care services for all members, Aetna Better Health provides interpreter services to non-English speaking and hearing impaired members. The provider and/or member may request face-to-face interpreter services, for a member’s scheduled provider appointment, by contacting Aetna Better Health member services at 1-855-300-5528.

Aetna Better Health uses 711 relay services for members that use a TDD/TTY device for hearing and speech impaired members. When a member prefers an available family member or friend to interpret for them or decides not to use Aetna Better Health’s hearing impaired support service line, this preference must be noted in the member’s medical record.

Aetna Better Health has alternate formats of the member handbook and member educational materials for non-English speaking and visually impaired members. This alternative format of member literature may be requested by contacting member services at 1-855-300-5528.
TED E. BEAR, MD, KIDS CLUB
Aetna Better Health sends our young members a birthday card during the month of their birth in conjunction with the EPSDT reminder mailings.

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 complete 7 or more prenatal visits with their obstetrical provider AND participate in the care management program.

The provider’s office is asked to confirm the attendance of 7 or more prenatal visits 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.

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

PROMISE REWARDS PROGRAM
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:

- Complete the post-partum visit. This visit must be within 21 – 56 days after the baby is born.
- Ask the obstetrical provider to complete the Promise Rewards form and return it to Aetna Better Health of Kentucky.

Providers will be responsible for completion of the rewards form at the health plan or member’s request.

AETNA BETTER HEALTH BETTER WAY TO HEALTH INCENTIVE PROGRAM
Members can earn gift cards after they complete the following checkups:

- $10 gift card for completing a Lead Screening test for children prior to their 2 birthday
- $10 gift card for completing a diabetic retinal eye exam for adults 18 – 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 7 days of discharge after a hospitalization for mental illness (6 years of age or older)

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.

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.
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 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/dpq/iforms+and+teaching+sheets.htm to access the appropriate form for this procedure.

**DIRECT ACCESS SERVICES**
The member may get the following covered services from any in-network provider of choice:

- Primary care vision services, including fitting eye glasses, provided by in-network ophthalmologists, optometrists and opticians
- Primary care dental and oral surgery services and evaluations by in-network orthodontists and prosthodontists
- Family planning services
- Maternity care for members under 18 years of age
- Immunization for children under 21 years of age
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Testing for Human Immunodeficiency Virus (HIV), HIV related conditions and other communicable disease
- Chiropractic services
- Women's health specialists

Aetna Better Health will evaluate the use of out of network providers for direct access services and reach out to high volume providers to determine if they are qualified and interested in enrolling in the Aetna Better Health network.
SECTION 5 - MEDICAL MANAGEMENT

UTILIZATION MANAGEMENT (UM) PROGRAM

PURPOSE
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 a UM issue, please call our toll-free member service line at 1-855-300-5528 from 7a.m. to 7p.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 discontinue 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**

We use MCG, formerly known as Milliman Care Guidelines® to ensure consistency in utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCG guidelines are updated regularly as each new version is published.

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 on the basis of 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 updated as applicable when 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.

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 MCG guidelines state “current role remains uncertain” for the requested service, the next criteria in the hierarchy should be consulted and utilized (this also applies to concurrent review and nonelective conditions):

- Criteria required by applicable state or federal regulatory agency
- Pharmacy clinical guidelines, when applicable
- Applicable MCG 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
- MCG 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 upon request and, upon request, to members and potential members 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.

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; and
• Provided in accordance with 42 CFR 440.230.

REQUESTING AUTHORIZATION
Providers may request authorization and submit notification Monday - Friday between the hours of 8a.m. – 6p.m. ET. See contact section page 12.

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.
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 business days of a denial. We’ll 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 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; or
- With a different medical director if the original medical director cannot be available within one business day; and
- 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 so.

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:

<table>
<thead>
<tr>
<th>Type of Decision</th>
<th>Decision</th>
<th>Initial Notification</th>
<th>Notification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent precertification</td>
<td>2 business days from receipt of request*</td>
<td>2 business days from receipt of request</td>
<td>Oral and/or written, dependent on type of notification</td>
</tr>
<tr>
<td>Non-urgent precertification</td>
<td>2 business days from receipt of the request*</td>
<td>2 business days from receipt of request</td>
<td>Oral and/or written, dependent on type of notification</td>
</tr>
<tr>
<td>Urgent concurrent review</td>
<td>1 calendar day from receipt of request*</td>
<td>1 calendar day from receipt of request*</td>
<td>Oral and/or written, dependent on type of notification</td>
</tr>
<tr>
<td>Retrospective review</td>
<td>30 calendar days from receipt of request*</td>
<td>30 calendar days from receipt of request</td>
<td>Oral and/or written, dependent on type of notification</td>
</tr>
</tbody>
</table>

All urgent precertification decisions are made within two business days, but not to exceed three calendar days, with the exception of retrospective review.

*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 make a decision, 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 make a decision to 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 make a decision to 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.

AUTHORIZATION CONFIRMATION
Upon approval of the requested service, Aetna Better Health will supply the following:

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

AUTHORIZATION CONFIRMATION VIA PROVIDER PORTAL
Providers may use our provider portal at aetnabetterhealth-kentucky.aetna.com to review authorization information. Below is a list of features available using this free, internet based tool for our Aetna Better Health providers:

• Look up authorizations (search by member, status, authorization number)
• View authorization detail
• Update an authorization
• Attach up to four (4) files

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 date 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 on a daily basis. 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.

PRE-ADMISSION REVIEW
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.
PRIOR AUTHORIZATION
The prior authorization process supports:

- 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 Commonwealth of Kentucky contract.
- 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 aetnabetterhealth-kentucky.aetna.com and refer to the authorization directory. If you do not have access to the portal, please contact Provider Relations 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 — SUMMARY
Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing and other health services before care is provided. The following is a summary listing of services that require prior authorization. It is not intended to be considered an all-inclusive listing. For a comprehensive and current listing of authorization requirements, please refer to the provider portal at aetnabetterhealth-kentucky.aetna.com.
### Prior authorization list (not all-inclusive)

**The following services require prior authorization:**

- All inpatient services (including Skilled Nursing Facility (SNF), Rehabilitation)
- All homecare services, including home infusion
- All services provided by non-participating providers
- Any miscellaneous code (unlisted codes usually ending in -99)
- All behavioral health and substance use services. Call **1-888-604-6106** to obtain authorization

#### Selected ambulatory procedures/services (Not all-inclusive)

<table>
<thead>
<tr>
<th>Procedure/Service</th>
<th>Procedure/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>AICD placement/replacement</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Certain GI scopes (see complete authorization grid for details)</td>
<td>Metabolic foods</td>
</tr>
<tr>
<td>Apheresis</td>
<td>Neuro-electrode implants</td>
</tr>
<tr>
<td>Bariatric surgery evaluations</td>
<td>Neuropsychological testing</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Neuro-stimulators</td>
</tr>
<tr>
<td>Breast surgery (selected)</td>
<td>Orthognathic surgery</td>
</tr>
<tr>
<td>Cardiac/pulmonary rehabilitation</td>
<td>Pain management services</td>
</tr>
<tr>
<td>Certain chemotherapy drugs (see provider relations representative for complete authorization grid for details)</td>
<td>Penile prosthesis</td>
</tr>
<tr>
<td>Chiropractic visits (after 12 visits)</td>
<td>Rehab services after initial evaluation (PT/OT/ST)</td>
</tr>
<tr>
<td>Cochlear implants</td>
<td>Selected other outpatient surgical procedures</td>
</tr>
<tr>
<td>Cosmetic/reconstructive services</td>
<td>(see provider portal for complete authorization requirements)</td>
</tr>
<tr>
<td>CT scans/MRI/MRA/PET scans (For non-emergent outpatient requests contact eviCore at 1-888-693-3211)</td>
<td>TMJ services</td>
</tr>
<tr>
<td>Durable medical equipment (DME) items with billed charges greater than $500. All DME Rentals require authorization.</td>
<td>Transplant services (including evaluation)</td>
</tr>
<tr>
<td>EPSDT Special Services</td>
<td>Treatment or excision of gum lesions</td>
</tr>
<tr>
<td>Experimental/Investigational services</td>
<td>Tubal ligation</td>
</tr>
<tr>
<td>Facial reconstruction</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>Vein procedures (stripping, injection, etc.)</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>Voluntary termination of pregnancy (covered only in cases of rape/incest endangerment of mother’s life)</td>
</tr>
<tr>
<td></td>
<td>Injectable medications (selected)</td>
</tr>
</tbody>
</table>
Prior authorization list (not all-inclusive)
The following services require prior authorization:

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperbaric oxygen therapy</td>
</tr>
</tbody>
</table>

Note: All non-participating provider referrals require prior authorization.

This abridged list is not intended to be an all-inclusive list of prior authorization requirements. Please visit our provider portal for complete authorization requirements.

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

A decision to admit observations stays must be made within the first 48 hours. If observation services result in an inpatient admission, notification must be made within one calendar day.

*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.

Specialty provider referrals
Aetna Better Health does not require PCPs to obtain authorizations to refer members to participating specialists for office level service with the exception of:

- 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, Section 2)

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 by 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
- TB screenings

The member may go to a non-participating provider only if the care is medically necessary, prior approved by Aetna Better Health, and an in-network provider is not available.

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.

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 www.aetnabetterhealth.com/kentucky for a copy of the Sterilization Consent form.

MATERNITY CARE
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 Aetna Better Health Maternity Risk Screening form. Please refer to the document library on the Aetna Better Health of Kentucky website at www.aetnabetterhealth.com/kentucky for a copy of the form.

All ultrasounds require prior authorization and will be reviewed for medical necessity.

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, 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 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 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 provider services 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.
**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
- 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, the facility and the member are sent written notification of any adverse determination. 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.

**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 after March 1, 2012 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 months from the date of service or in the case of retroactive eligibility, twelve months from the date the member was added to our membership roll.

**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, whether billed charges are necessary and reasonable, and 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, local market’s 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 members’ 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

**INTEGRATED CARE MANAGEMENT (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 supports/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 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.

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, concurrent review/prior authorization referral, as well as member and provider referral.

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, truly 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, longstanding 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.

**HIGH RISK OB PROGRAM**

Our goal is to have healthy mothers and babies. In an effort 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.
SPECIAL NEEDS RISK 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 requirements, 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.

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.

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.

INPATIENT AND OUTPATIENT SERVICES

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 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 in the event that 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 at the time of notification. 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.

**EMERGENCY SERVICES**

Aetna Better Health will make provisions for, and advise members on the policies of accessing emergency services based on the following definition:

An emergency medical condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient 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 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.
Emergency services are not subject to prior authorization. Aetna Better Health must be notified within 1 calendar day following an emergency admission, service, or procedure to request notification and/or continuation of treatment for that condition if such service requires authorization.

Aetna Better Health will reimburse non-participating providers for the evaluation and/or stabilization of emergency conditions according to Commonwealth guidelines, as described above. 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.

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

**MEDICAL SCREENING EXAMINATION**

Aetna Better Health of Kentucky reviews emergency department (ED) claims to ensure that claims for emergency medical conditions meet the prudent layperson standard, as defined in 907 KAR 3:130, Section 1(4).

The “prudent layperson standard” is the standard for determining the existence of an emergency medical condition whereby a prudent layperson who possesses an average knowledge of health and medicine determines that a medical condition manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

When Aetna Better Health receives an ED claim, it will review such claim and if there is a question as to whether the prudent layperson standard was satisfied, the facility’s immediate payment, as reflected on the Remittance Advice (RA), will be the standard Medical Screening Exam (MSE) fee of $50 and the RA will request the facility to submit medical records for further review. Upon receipt of such records, Aetna Better Health clinical staff will review to ensure the prudent layperson standard was met. Upon appropriate clinical validation, the claim will be further adjudicated as an emergency service and paid accordingly. ED claims that are not in question will not be subject to this process.

If Aetna Better Health determines that the prudent layperson standard was not satisfied, the facility’s payment will be limited to the Medical Screening Exam (MSE) rate of $50. If your facility does not respond to a request for records within the specified timeframe, the claim will be denied for insufficient information and only the MSE payment will be issued. Thereafter, our standard provider appeal process will apply.

**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, 8a.m.–6p.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 add additional 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 certain supplies require prior authorization. Supplies exceeding the allowable quantity will also require prior authorization. Please refer to the Aetna Better Health website at 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.
**TRANSACTION 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 of time, approximately one (1) visit, evaluation and/or month of supplies in the event medical necessity is not provided at the time of the request.

Continued authorization of medical supplies or services must be medically necessary. Transition to a participating provider for the services will be required if the non-participating provider will not be entering into a contractual relationship with Aetna Better Health.
SECTION 6 - VISION SERVICE

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.

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

MEMBER ELIGIBILITY VERIFICATION
Members are eligible to receive one exam of eye health and visual acuity per calendar year. Members under age 21 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 provider relations representative or you may call Avēsis at 1-855-214-6776.
SECTION 7 - PHARMACY

PHARMACY SERVICES
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, RxGROUPRX8831. 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
- 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 of these 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 State 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 days’ supply, or course of therapy as related to the particular 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
- Gender edits - may be placed based on the indications of the FDA, safety and effectiveness reviews
- 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: [www.aetnabetterhealth.com/kentucky](http://www.aetnabetterhealth.com/kentucky).

**Covered Drugs and Services**
Aetna Better Health of Kentucky has a preferred drug list located at [www.aetnabetterhealth.com/kentucky](http://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 provider relations representative.

The preferred drug list is constructed of select medications which meet the strict standards of safety, efficacy and best value using comparative models though 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 members use. The adoption of using a preferred drug or generic medications will provide the prescriber a smooth process to allow the member to receive medications without call backs and delays at the pharmacy.

This list of preferred medications is update at least annually. 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 in order 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.

Devices with limits: Aerochamber (2-year maximum) and Lifescan® Glucometers (1-year maximum)

**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 will be required to file a FDA MedWatch response form located at [www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/ucm2007307.htm](http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/ucm2007307.htm).
**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.

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 www.aetnabetterhealth.com/kentucky. Our members and providers are notified annually of the formulary via our member newsletter, provider newsletter and on the website at www.aetnabetterhealth.com/kentucky.

*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, 8a.m. to 8p.m. ET. The pharmacy help desk is available 24 hours a day, 7 days a week.

Providers may also fax prior authorization requests to 1-855-300-5528. We are able to receive and log fax requests 24 hours a day, 7 days a week.

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 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 www.aetnabetterhealth.com/kentucky lists the covered self-administered injectable medication covered on the formulary.

**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, 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.
- Over the counter (OTC) medications are excluded (except for those specifically on the formulary).
- 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.

**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.

<table>
<thead>
<tr>
<th>Prescription drugs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home infusion therapy</td>
<td>Limited to administration by parent or guardian in the home</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Non-preferred brand copay is applicable to all members (including those typically excluded from copays)</td>
</tr>
<tr>
<td></td>
<td>Family planning, no copays</td>
</tr>
<tr>
<td></td>
<td>Tobacco cessation, no copays</td>
</tr>
<tr>
<td></td>
<td>2nd Generation Antipsychotics and Injectable Antipsychotics</td>
</tr>
<tr>
<td></td>
<td>$4 Non Preferred</td>
</tr>
<tr>
<td></td>
<td>Anticonvulsants, non-preferred bands</td>
</tr>
<tr>
<td></td>
<td>$4 Non-Preferred brand</td>
</tr>
<tr>
<td></td>
<td>Oral oncology, non-preferred brands</td>
</tr>
<tr>
<td></td>
<td>$4 Non-preferred brand</td>
</tr>
<tr>
<td></td>
<td>Diabetic supplies</td>
</tr>
<tr>
<td></td>
<td>-- Meters, no copays</td>
</tr>
<tr>
<td></td>
<td>-- Test strips, control solutions, insulin needles, lancets, etc.</td>
</tr>
</tbody>
</table>
SECTION 8 - QUALITY IMPROVEMENT

EXECUTIVE QUALITY IMPROVEMENT COMMITTEE (EQIC)
Aetna Better Health of Kentucky’s Board of Directors has delegated oversight of the Aetna Better Health Quality Improvement (QI) program to the Executive Quality Improvement 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 Executive Quality Improvement Committee (EQIC) reports to the Board of Directors. The EQIC 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 EQIC committee is responsible for evaluating, implementing and monitoring the effect of quality improvement policies, procedures, and programs in an effort 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 or by calling the health plan.

QUALITY MANAGEMENT/UTILIZATION MANAGEMENT (QM/UM) COMMITTEE
The QM/UM is a sub-committee of the EQIC that provides physician review of, and recommendations on, the Health Plan’s Quality and Utilization Management Programs to the EQIC to ensure sufficient clinical input. The committee is an advisory committee whose recommendations are forwarded to the EQIC 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 Vice President of Health Services, Director/Manager of Quality Improvement, Director/Manager 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 assure appropriate follow-up.
- Conducting professional review activities 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. Aetna Better Health maintains a quality management program that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.

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, Provider 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 via on-going 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

**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/UMC). 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 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:

• Coronary artery disease – American Heart Association and the National Heart, Lung and Blood Institute Disease and Condition Index, Coronary Artery Disease
• Chronic kidney disease – kidney disease Improving Global Outcomes and the National Kidney Foundation
• Chronic obstructive pulmonary disease – Global Initiative for Chronic Obstructive Pulmonary Disease and the American Lung Association
• Diabetes – American Diabetes Association
• 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

The Clinical Practice and Preventive Health guidelines are available on the Aetna Better Health of Kentucky website 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 provider relations representative. 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 to 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 their 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 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 requires that medical records, as well as, appointment logs, be maintained for a minimum of seven (7) years and in compliance with federal and state regulations.

• Aetna Better Health contracts require that providers cooperate with QI activities including:
  • 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 10 business days of receipt of the request.

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.

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 10 business days of receipt of the request.

PCP panel listings, including new members, are produced monthly 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.
**Provider On-going Monitoring**

The Aetna Better Health policy and process for on-going 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 provider relations representative 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 provide 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.

**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 noncompliance, professional competency and/or conduct. For noncompliance, 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 on-going monitoring and the provider oversight dispute resolution process, please contact your provider relations representative.

**Cultural Competence**

Delivering culturally competent health services requires the understanding of culturally-defined health related needs of individuals, families, and communities, as well as the understanding of culturally-based belief systems regarding etiology of illness, disease, health and healing. Aetna Better Health supports the education of providers and their employees regarding cultural competence principles and in complying with Title VI and Title VII of the Civil Rights Act and the Americans with Disabilities Act.
There are five (5) essential elements that contribute to a provider’s ability to become culturally competent. The provider should:

- Value diversity
- Have the capacity for cultural self-assessment
- Be conscious of the dynamics inherent when cultures interact
- Institutionalize cultural knowledge
- Develop adaptations to service delivery reflecting an understanding of diversity between and within cultures

**MEETING MEMBER’S CULTURAL AND LINGUISTIC NEEDS**

The Aetna Better Health membership is comprised of individuals, who upon enrollment, may declare languages other than English and individuals with visual or hearing impairment. The principal languages as defined by the Commonwealth contract are English and Spanish.

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.

To meet the needs of our speech, hearing and visually impaired members, the Member Handbook is also offered in alternate formats upon request. Aetna Better Health tracks requests received for any of these alternate versions. Aetna Better Health also monitors for any grievances related to language services.

**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 on the basis of 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 enforeceable 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 be in compliance:

- 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)

**ADVANCED DIRECTIVES**

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.

**ADVANCED HEALTH CARE DIRECTIVE**

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 individuals information regarding advanced directives
• Requires institutions to provide on-going 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](http://www.ag.ky.gov)
- American Bar Association: [www.abanet.org/aging/toolkit/home.html](http://www.abanet.org/aging/toolkit/home.html)
- Aging with Dignity: [www.agingwithdignity.org](http://www.agingwithdignity.org)
- Kentucky Bar Association: [www.kybar.org](http://www.kybar.org)
- National Hospice and Palliative Care Organization: [www.caringinfo.org](http://www.caringinfo.org)
- Children’s Hospice International: [www.chionline.org](http://www.chionline.org)

**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:
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)). A number of 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.

**HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)**

**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**

*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.

*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)

*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 test 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.

*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.
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.

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

According to the terms of their contract, provider may not bill either the plan or the member for copies of medical records related to HEDIS®.

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 provider relations representative or the Quality Improvement department for more information.

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 provider relations representative or the Quality Improvement department for more information.

Helpful HEDIS® documentation tips for providers

Beginning on the next page, you will find helpful tips for documentation when providing HEDIS® related services. Providers may contact the HEDIS® department to schedule on site or webinar based HEDIS® training. Please call 1-855-737-0872 to speak with a HEDIS® outreach coordinator to schedule this training.
### Helpful HEDIS Documentation Tips for Providers

<table>
<thead>
<tr>
<th>HEDIS Measure Definitions</th>
<th>What You Can Do</th>
<th>Coding Tips</th>
</tr>
</thead>
</table>
| **BCS**
Breast Cancer Screening
Women 50-74 years of age with one or more mammograms within last 2 years. |
Document member education on the benefits of early detection of breast cancer.
Encourage mammography to all women who are within risk group. |
| Procedure Codes 77055-77057 |
| HCPCS G0202, G0204, G0206 |
| Diagnosis Codes 87.36, 87.37 |
| UB Rev Codes 0401, 0403 |
| Mastectomy Codes |
Diagnosis 85.41—8, OHTV0ZZ, Z90.13 |
| Procedure Codes 19180, 19200, 19220, 19240, 19303-7 |
| Bilateral Modifiers 50, 09950 |
| **CCS**
Cervical Cancer Screening
Women 21-64 years of age with one or more Pap tests within the last 3 years or for women 30-64 years of age, a cervical cytology and human papillomavirus (HPV) co-testing with in the last 5 years. |
Women who have had a total hysterectomy with no residual cervix are excluded. **TOTAL** hysterectomy MUST be documented in history or problem list. Documentation of just hysterectomy does not count.
Notation of Pap test located in progress notes MUST include the lab results in order to meet NCQA® requirements.
Cervical cytology and human papillomavirus test must be completed four or less days apart in order to qualify for every 5 years testing. |
| Procedure Codes 88141-88143, 88147, 88150, 88152-88154, 88164-88167, 88174, 88175 |
| HCPCS G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 |
| UB Rev Codes 0923 |
| HPV |
| Procedure Codes 87620-87622 |
| LOINC Codes 21440-4, 30167-2, 38372-9, 49896-4, 59420-0, 75406-9, 75694-0 |
| Hysterectomy Codes 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135 , OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ, Q51.5, Z90.710, Z90.712 |
| **CHL**
Chlamydia Screening in Women
Women 16-24 years of age who are identified as sexually active with a Chlamydia test annually. |
Assist with member education of STD. Perform routine test for Chlamydia, document and submit timely. Urine Chlamydia test is the easiest to perform. |
| Procedure Codes 87110, 87270, 87320, 87490-87492, 87810 |
| LOINC Codes 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8 |
### Helpful HEDIS Documentation Tips for Providers

<table>
<thead>
<tr>
<th>HEDIS Measure Definitions</th>
<th>What You Can Do</th>
<th>Coding Tips</th>
</tr>
</thead>
</table>
| **ART** | **Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis**  
Members 18 years of age or older who were diagnosed with rheumatoid arthritis and were prescribed a disease-modifying anti-rheumatic drug (DMARD). | Prescribe DMARDs to members with rheumatoid arthritis.  
**Exclusions:** A diagnosis of HIV anytime during the member’s history through December 31 or a diagnosis of pregnancy during the year. | **Diagnosis Codes**  
714.0, 714.1, 714.2, 714.81, M05.00-M06.9  
**DMARD HCPCS**  
J0129, J0135, J0177, J0178, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310 |
| **CBP** | **Controlling High Blood Pressure**  
Members 18-85 years of age with a diagnosis of hypertension (HTN) and whose BP is adequately controlled. | If BP elevated (140/90 or greater) at initial vital sign assessment, alleviate potential factors that might cause temporary elevation and retake BP during exam.  
If elevation persists, treat as necessary and retake BP. Document all measurements and efforts to obtain BP control.  
Schedule follow up visits to monitor effectiveness of BP medication. | **Diagnosis Codes**  
401.0, 401.1, 401.9, I10  
**Blood Pressure Procedure Codes Systolic BP < 140**  
3074F, 3075F  
**Blood Pressure Procedure Codes Diastolic <90**  
3078F, 30709F |
| **CDC** | **Comprehensive Diabetes Care**  
Members 18-75 years of age with diabetes should have each of the following at least annually: HbA1C testing, medical attention for nephropathy, a retinal eye exam and blood pressure monitoring at each visit. | Document results of HbA1C and Microalbumin exams annually or more often as needed.  
A current medication list indicating that a member is on an ACE/ARB medication such as Lisinopril or Losartan is appropriate for nephropathy attention.  
Refer member to Optometrist for Dilated Retinal Eye Exam annually. Obtain the results from the eye provider and place a copy in the member’s medical record. | **Diagnosis Codes:**  
**HbA1c Procedure Codes**  
82042 - 82044, 84156, 3060F, 3061F  
**HbA1c level 7.0-9.0**  
3045F  
**HbA1c level less than 7.0**  
3044F  
**HbA1c level greater than 9.0**  
3046  
**Nephropathy Screen Procedure Codes**  
82042 - 82044, 84156, 3060F, 3061F  
**Blood Pressure Procedure Codes Systolic BP < 140**  
3074F, 3075F  
**Blood Pressure Procedure Codes Diastolic <90**  
3078F, 30709F |
| **SPR** | **Use of Spirometry Testing in the Assessment and Diagnosis of COPD.**  
Members age 40 years or older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry to confirm the diagnosis. | Encourage members that are diagnosed with COPD to have a spirometry test performed.  
Members who have been diagnosed by another physician should be encouraged to have the testing to confirm the diagnosis. | **COPD Diagnosis Codes:**  
493.2 - 493.22, 496, 492.0, 492.8, 491.0, 491.2 - 491.22, 491.8, 491.9  
**Spirometry Procedure Codes:**  
94010, 94014-94016, 94060, 94070  
94375, 94620 |
| **ABA** | **Adult BMI Assessment**  
Members 18-74 years of age with their body mass index (BMI) and weight documented annually. | Perform and document criteria of Ht/Wt/BMI calculation at each visit.  
*Pregnant members are excluded from this measure*  
Use correct diagnosis and procedure codes and submit claims timely. | **Diagnosis Codes**  
V85.0, V85.1, V85.21-V85.25, V85.30-V85.39, V85.41-V85.45, V85.51-V85.54 |
<table>
<thead>
<tr>
<th>HEDIS Measure Definitions</th>
<th>What You Can Do</th>
<th>Coding Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>W15</strong></td>
<td>Never miss an opportunity! Exam requirements can be performed during a sick visit or a well-child exam. Documentation MUST include ALL three criteria: health education/guidance, physical exam, developmental health and history. Anticipatory guidance must be documented.</td>
<td><strong>Diagnosis Codes</strong>&lt;br&gt; V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9, Z00.00-Z00.129, Z00.5, Z00.8, Z02.1-Z02.9&lt;br&gt; <strong>Procedure Codes:</strong> 99381-5, 99391-5, 99432, 99461</td>
</tr>
<tr>
<td>Well Child 15 months</td>
<td>Members 0-15 months of age with 6 comprehensive well child visits. Minimum of 6 well visits required before 15 months old</td>
<td></td>
</tr>
<tr>
<td><strong>W34</strong></td>
<td>Never miss an opportunity! Exam requirements can be performed during a sick visit or a well-child exam. Documentation MUST include ALL three criteria: health education/guidance, physical exam, developmental health and history. Anticipatory guidance must be documented.</td>
<td><strong>Diagnosis Codes</strong>&lt;br&gt; V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9, Z00.00-Z00.129, Z00.5, Z00.8, Z02.1-Z02.9&lt;br&gt; <strong>Procedure Codes:</strong> 99382-5, 99391-5, 99461</td>
</tr>
<tr>
<td>Well Child 3-6 years</td>
<td>Members 3-6 years of age with at least 1 comprehensive well child visits annually. Minimum of 1 visit required annually</td>
<td></td>
</tr>
<tr>
<td><strong>WCC</strong></td>
<td>Document height, weight and BMI percentile. Discussion and documentation of nutrition and physical activity during at least one office visit annually. <em>This may be done during a sick visit or well child exam.</em></td>
<td><strong>BMI Diagnosis Code</strong> V85.0-V85.54, Z68.51-Z68.54&lt;br&gt; <strong>Nutrition Counseling</strong>&lt;br&gt; <strong>Diagnosis Code</strong> V65.3, Z71.3&lt;br&gt; <strong>Procedure Codes</strong> 97802-97804&lt;br&gt; <strong>HCPCS</strong> G0447, G0270, G0271, S9449, S9452, S9470&lt;br&gt; <strong>Physical Activity Counseling</strong>&lt;br&gt; <strong>Diagnosis Code</strong> V65.41&lt;br&gt; <strong>HCPCS</strong> G0447, S9451</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
<td>Children age 3-17 years of age who had a visit with a PCP or OB/GYN and who had BMI percentile documentation, and counseling for nutrition and physical activity</td>
<td></td>
</tr>
<tr>
<td><strong>AWC</strong></td>
<td>Make certain to notate physical and mental health development, physical exam and health education. Never miss an opportunity! Exam requirements can be performed during a sick visit or a well visit exam. Documentation must include ALL 3 criteria. Anticipatory guidance must be documented.</td>
<td><strong>Diagnosis Codes</strong>&lt;br&gt; V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, Z00.00-Z00.129, Z00.5, Z00.8, Z02.1-Z02.9&lt;br&gt; <strong>HCPCS</strong> G0438, G0439&lt;br&gt; <strong>Procedure Codes</strong> 9381-99385, 99391-99395, 99461</td>
</tr>
<tr>
<td>Adolescent Well Care Visits</td>
<td>Members 12-21 years of age with at least one comprehensive well care visit with a primary care practitioner or an OB/GYN practitioner annually. Minimum of 1 Required</td>
<td></td>
</tr>
<tr>
<td><strong>IMA</strong></td>
<td>Educate staff to schedule PRIOR to 13th birthday. Document and submit timely with correct code.</td>
<td><strong>Tdap Procedure Codes</strong> 90715&lt;br&gt; <strong>Td Procedure Codes</strong> 90714, 90718&lt;br&gt; <strong>Tetanus Procedure Code</strong> 90703&lt;br&gt; <strong>Diphtheria Procedure Code</strong> 90719&lt;br&gt; <strong>Meningococcal Procedure Codes</strong> 90733, 90734</td>
</tr>
<tr>
<td>Immunizations in Adolescents</td>
<td>Members 10-13 years of age who received 1 Meningococcal and 1 Tdap vaccine or 1 Td booster. Offer HPV Vaccine to females age 9 to age 13. Three doses should be completed prior to age 13.</td>
<td><strong>Procedure Codes</strong> 90649, 90650, 90651</td>
</tr>
<tr>
<td><strong>HPV</strong></td>
<td>Hours Papillomavirus Vaccine for Female Adolescents Females between age 9 and 13 years administered 3 doses of HPV vaccine.</td>
<td></td>
</tr>
<tr>
<td>HEDIS Measure Definitions</td>
<td>What You Can Do</td>
<td>Coding Tips</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>CIS/LCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>Educate office staff to schedule appointments PRIOR to 2nd birthday. Perform Outreach to members to obtain appointment.</td>
<td>DTaP Procedure Codes 90698, 90700, 90719, 90721, 90723</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>Educate parents/guardians regarding the importance of having their child immunized and keeping appointments.</td>
<td>IPV Procedure Codes 90698, 90713, 90723 Hib Procedure Codes 90645-90648, 90698, 90721, 90748 HepB Procedure Codes 90723, 90740, 90744, 90747, 90748</td>
</tr>
<tr>
<td>Children who received recommended Vaccinations prior to second birthday.</td>
<td>Immunizations recommended: 4 DTaP/DT, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 Rotavirus and 2 Influenza vaccines. Document in medical record if member has evidence of the disease for which immunization is intended or contraindication due to anaphylactic reaction.</td>
<td>HCPGs G0010</td>
</tr>
<tr>
<td>Children who had one or more lead blood test for lead poisoning by their second birthday.</td>
<td><em>Document parental refusal.</em></td>
<td>Diagnosis Codes 070.2, 070.3, V02.61 Prevnar Procedure Codes 90669, 90670</td>
</tr>
<tr>
<td>FPC</td>
<td>RN visits for education do not count in HEDIS. They must see a prescribing provider. Encourage members to attend to all pre-natal visits.</td>
<td>VZV Procedure Codes 90710, 90716</td>
</tr>
<tr>
<td>Frequency of Prenatal Care</td>
<td>Educate staff to schedule first appointment with the MD, DO, NP or PA in the first trimester.</td>
<td>Diagnosis Codes 052, 053 MMR Procedure Codes 90707, 90710 Measles Procedure Code 90705</td>
</tr>
<tr>
<td>Pregnant members that had the following number of expected prenatal visits:</td>
<td>RN visits for education do not count in HEDIS. They must see a prescribing provider. Encourage attendance for postpartum visit.</td>
<td>Diagnosis Code 055 Measles/Rubella Procedure Code 90708 Mumps Procedure Code 90704</td>
</tr>
<tr>
<td>&lt;21% of expected visits</td>
<td>Please Note: a C-section incision check is not</td>
<td>Diagnosis Code 072 Rubella Procedure Code 90706</td>
</tr>
<tr>
<td>21% - 40% of expected visits</td>
<td>Prenatal Procedure Codes 99201-99205, 99211-99215, 99241-99245, 0514</td>
<td>Diagnosis Code 056</td>
</tr>
<tr>
<td>41% - 60% of expected visits</td>
<td>Stand Alone Prenatal Visits 99500, 0500F, 0501F, 0502F</td>
<td>Rubella Antibody Procedure Code 86762 VZV Procedure Code 90710, 90716</td>
</tr>
<tr>
<td>61% - 80% of expected visits</td>
<td>Bundled Prenatal Service Codes 59400, 59425, 59426, 59510, 59610, 59618</td>
<td>Diagnosis Code 052.0-052.2, 052.7-052.9, 053.0-053.2, 053.71, 053.79, 053.8, 053.9 Rotavirus 2 dose Procedure Code 90681 Rotavirus 3 dose Procedure Code 90680 HepA Procedure Code 90633</td>
</tr>
<tr>
<td>≥81% of expected visits</td>
<td>HCPGs G0009</td>
<td>Diagnosis Code 070.0, 070.1 Flu Procedure Code 90655, 90657, 90661, 90662, 90673, 90685</td>
</tr>
<tr>
<td>PPC</td>
<td>Prenatal Procedure Codes 99201-99205, 99211-99215, 99241-99245, 0514</td>
<td>HCPCS G0008</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care</td>
<td>RN visits for education do not count in HEDIS. They must see a prescribing provider. Encourage attendance for postpartum visit.</td>
<td>Lead Procedure Code 83655</td>
</tr>
<tr>
<td>Pregnant members with prenatal care during 1st trimester and Postpartum Care between 21-56 days after delivery.</td>
<td>Please Note: a C-section incision check is not</td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis Codes**
- 070.2, 070.3, V02.61 for Prevnar
- 052, 053 for MMR
- 055 for Measles/Rubella
- 072 for Rubella
- 056 for Rubella Antibody
- 052.0-052.2, 052.7-052.9, 053.0-053.2, 053.71, 053.79, 053.8, 053.9 for Rotavirus
- 90681 for Rotavirus 2 dose
- 90680 for Rotavirus 3 dose
- 90680 for HepA
- 070.0, 070.1 for Flu

**Procedure Codes**
- 90698 for DTap
- 90700 for IPV
- 90719 for MMR
- 90721 for Hib
- 90723 for HepB
- 90645-90648 for PCV
- 90744, 90747, 90748 for Influenza
- 83655 for Lead
- 90710, 90716 for VZV
- 90669, 90670 for Prevnar
- 90633 for HepA
A postpartum visit, the member must return for the full postpartum checkup between 21 and 56 days after delivery.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>G0463, T1015</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB Rev Code</td>
<td>0514</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
<td>630-639, V22, V23, V28</td>
</tr>
<tr>
<td>Postpartum Bundled Services</td>
<td>59410, 59515, 59614, 59622</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>57170, 58300, 59430, 99501, 0503F</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
<td>V24.1, V24.2, V25.11-V25.13, V72.31, V27.32, V76.2</td>
</tr>
</tbody>
</table>
## Section 9 - Claims and Reimbursement Procedures

### 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](http://www.nucc.org) and for the UB form visit [www.nubc.org](http://www.nubc.org). These include, where applicable:

<table>
<thead>
<tr>
<th>Block</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-A</td>
<td>Insureds ID</td>
</tr>
<tr>
<td>02</td>
<td>Patient name</td>
</tr>
<tr>
<td>03</td>
<td>Patient DOB and gender</td>
</tr>
<tr>
<td>04</td>
<td>Insureds name</td>
</tr>
<tr>
<td>05</td>
<td>Patient address &amp; telephone #</td>
</tr>
<tr>
<td>06</td>
<td>Patient relationship to the insured</td>
</tr>
<tr>
<td>10</td>
<td>Patient condition relationship</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s information</td>
</tr>
<tr>
<td>13</td>
<td>Patient or authorizing person assignment of payment</td>
</tr>
<tr>
<td>14</td>
<td>Illness, injury, pregnancy date</td>
</tr>
<tr>
<td>21</td>
<td>Valid diagnosis code (s)</td>
</tr>
<tr>
<td>23</td>
<td>Authorization number</td>
</tr>
</tbody>
</table>

For each procedure include:

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

### General Claims Information and Requirements
Electronic claim submission offers providers the fastest and most efficient claims adjudication and reduces office paperwork and mailing costs. Contact your provider relations representative 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 claim(s) (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 payor of last resort in most instances. For details, refer to “National Provider Identifier (NPI) Number and Taxonomy”.

All CMS 1500 claim must be submitted with rendering and billing NPI and taxonomy. UB 04 claims must be submitted with billing NPI and taxonomy. NPI and taxonomy records must match the Commonwealth of Kentucky’s provider file for the date of service. Claims not matching the provider file will be denied.

The National Provider Identifier Number (NPI) is a 10-digit provider number assigned by CMS. All providers must use their NPI number on all claims submitted to Aetna Better Health. To apply for this free NPI number, visit the National Plan/Provider Enumeration System (NPPES) website [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov).

The CMS and UB claim forms contain fields specifically for the NPI information. On the CMS form the rendering provider’s (Box 31) NPI number is placed in the bottom half of field 24I. The NPI for the billing provider in Box 33 is placed in the field 33A. Additionally, providers may send a NPI number for the facility where services were rendered in Box 32A. On the UB form the billing provider listed in Box 1 on this form places their NPI number in field 56.

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.

- 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 HCPC 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 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.

**ORDERING, REFERRING, AND PRESCRIBING REQUIREMENTS**

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 provider 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:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 Dentist</td>
<td>78 Certified Nurse Practitioner</td>
</tr>
<tr>
<td>64 Physician</td>
<td>80 Podiatrist</td>
</tr>
<tr>
<td>74 Nurse Anesthetist</td>
<td>85 Chiropractors</td>
</tr>
<tr>
<td>77 Optometrist</td>
<td>95 Physician Assistant</td>
</tr>
</tbody>
</table>

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:

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

**Provider Type** | **All Crossover Services Billed By:**
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>54 Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

Provider type 34, Home Health Agencies, (and all other providers submitting on the UB-04) is still required to submit an Attending Provider on all of 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, prescribing information is required.

As of July 1, 2017, claims that are not billed correctly will not be accepted and will need to be corrected and resubmitted.

CLAIM PAYMENTS AND PROCESSING TIMEFRAMES
In accordance with the Kentucky law, within 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 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 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 95% of clean claims submitted by a provider within 30 days of receipt, and 99% of clean claims within 90 days of receipt. Claims that are not considered clean, as defined in this Provider Manual, may take additional time for processing.

CLAIM CODING
Claims must be submitted with valid CPT, HCPCS, revenue codes and modifiers, 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 a clean claim.

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 must be submitted directly to Aetna Better Health at the following address:

INITIAL AND CORRECTED SUBMISSIONS
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.

<table>
<thead>
<tr>
<th>Claim type</th>
<th>Timely filing guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial claims (Outpatient/professional/ancillary Services)</td>
<td>365 from the date of service (DOS)</td>
</tr>
<tr>
<td>Initial claims (Inpatient Services)</td>
<td>365 from the date of discharge (DOD)</td>
</tr>
<tr>
<td>Retroactively activated member, including newborn claims</td>
<td>365 days from the date of enrollment into the Aetna Better Health eligibility files</td>
</tr>
<tr>
<td>Coordination of Benefits (All provider types)</td>
<td>365 days from date of primary carrier remittance advice</td>
</tr>
<tr>
<td>Adjusted/corrected claims</td>
<td>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.</td>
</tr>
</tbody>
</table>

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND TAXONOMY
All CMS 1500 claim must be submitted with rendering and billing NPI and taxonomy. UB 04 claims must be submitted with billing NPI and taxonomy. NPI and taxonomy records must match the Commonwealth of Kentucky’s provider file for the date of service. Claims not matching the provider file will be denied.

The National Provider Identifier Number (NPI) is a 10-digit provider number assigned by CMS. All providers must use their NPI number on all claims submitted to Aetna Better Health. To apply for this free NPI number, visit the National Plan/Provider Enumeration System (NPPES) website www.nppes.cms.hhs.gov.

The CMS and UB claim forms contain fields specifically for the NPI information. On the CMS form the rendering provider’s (Box 31) NPI number is placed in the bottom half of field 24J. The NPI for the billing provider in Box 33 is placed in the field 33A. Additionally, providers may send a NPI number for the facility where services were rendered in Box 32A. On the UB form the billing provider listed in Box 1 on this form places their NPI number in field 56.

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.
**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 [www.aetnabetterhealth.com/kentucky](http://www.aetnabetterhealth.com/kentucky). Please verify with your practice management vendor regarding file formatting and information on how to submit claims.

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Payor ID #</th>
<th>Claim type</th>
<th>Contact number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Healthcare</td>
<td>128KY</td>
<td>UB and CMS</td>
<td>1-877-469-3263</td>
</tr>
</tbody>
</table>

**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 format. A value in this field equal to “7” indicates a replacement claim. Additionally, Aetna Better Health accepts the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Replacement of prior claim</td>
</tr>
<tr>
<td>8</td>
<td>Void/cancel of a prior claim</td>
</tr>
</tbody>
</table>

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 original submission. The above field code values are for 5010 professional claims. Institutional claims submission use 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.

**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; or
- 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; or
- A copy of the other insurance carrier’s EOB received 12 months after the date of service but less than six 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.
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 payor 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.

Electronic Funds Transfer (EFT)

EFT is an option for capitation checks and 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 aetnabetterhealth-kentucky.aetna.com.

To enroll in EFT, complete the form found on the provider portal at aetnabetterhealth-kentucky.aetna.com or at the Aetna Better Health website www.aetnabetterhealth.com/Kentucky or contact your provider relations representative.

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). For questions concerning ERAs, please send an email with your question to KYProviderRelations@aetna.com.

Remittance Advice

Aetna Better Health generates twice weekly Remittance Advice Summaries to all providers for all paid, pended or processed claims. A copy of the Aetna Better Health Remittance Advice Summary and information on how to read the report are listed below.
CLAIMS INQUIRY CLAIMS RESEARCH (CICR)
The Aetna Better Health CICR representatives are available Monday – Friday, 7 a.m.–7 p.m. ET to answer questions related to the processing of claims submitted to Aetna Better Health. Please have your NPI Number and tax identification number (TIN) available.

CLAIM SPECIFIC REQUIREMENTS

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 modifier. 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 unit and include a 50 modifier. Claims for bilateral procedures noted with a 50 modifier and containing more than one 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.

**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.

**IMMUNIZATIONS**

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.

**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.

**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 provider relations representative. Your submission should include the effective date of the change. Aetna Better Health should receive the change at least 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 UB04 form. If a claim is submitted with conflicting information in Field 33, Line 1 of the CMS form or Block 2 of the UB04, 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 your provider relations representative.

**CLINICAL CLAIMS EDITING**

Aetna Better Health uses claims edit applications such as Cotiviti, 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.

**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 to such service, including but not limited to, the failure of Provider to obtain required preauthorization. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void.

Provider shall collect from the member and may retain only co-payments, deductibles or charges for services which are not covered services under the member’s benefit plan as long as the charges are not charges for reimbursable services. In the event a member requests non-covered services, a provider may render non-covered services to a member so long as provider has obtained a detailed, easy to understand, request for such non-covered services stated clearly in writing and the member clearly understands and has been informed and acknowledged in writing that Aetna Better Health will not cover such services. This does not prohibit provider from pursuing available legal remedies including, without limitation, collecting from any insurance carrier providing coverage to an individual.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health provider relations representative 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.

**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.

**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 48-hour notice prior to requesting access under this subsection.

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

**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. When the collection advice is received, please reference your previous remittance advices to determine what created the negative balance.

If your office does not have enough claim volume to clear this negative balance within a month, please refund the overpayments. It is best to remit the sum of the negative claims only. 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 - Finance  
P. O. Box 842605  
Dallas, TX 75284-2605

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 over-paid claims up to 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 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 60 days from the postmark date/electronic delivery date, and submit additional relevant information to Aetna Better Health.
such instance, Aetna Better Health shall not proceed with the recoupment until the dispute is resolved. Disputes shall be resolved within 30 days of receipt through Aetna Better Health’s provider appeals process, outlined in Section 10 - Complaint Process for Providers and Members of 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 - Finance
P. O. Box 842605
Dallas, TX 75284-2605

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 to contact your local Internal Revenue Service (IRS) office.
SECTION 10 - COMPLAINT PROCESS FOR PROVIDERS AND MEMBERS

PROVIDER COMPLAINT AND APPEAL PROCESS
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 hours a day, every day.
- Call us to tell us about your appeal or complaint. Our phone number is 1-855-300-5528 (TTY users dial 711/TDD users dial 1-800-627-4702). We’re open Monday through Friday. Our hours are 7a.m. to 7p.m. ET.
- File a complaint in person by coming to our office at the address below.
- Write to us at the address below about your complaint or appeal.

Aetna Better Health of Kentucky
Attention: Complaint and Appeal Department
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

Faxing complaints and appeals are welcomed and are actually preferred. Our secure fax number is 1-855-454-5585. Faxing your complaint or appeal may make it faster for us to process it. Faxing saves you, the provider postage expense, as well as time. Also, you can fax over your information at any time of the day or week. For standard appeals, we’ll always send you a letter within five 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).

Both complaints and appeals can be clinical or administrative. Clinical cases are about decisions we make based in whole or in part on medical judgment. 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.

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 or 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.
**PROVIDER COMPLAINTS**

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

Based on guidelines from the state, we accept provider complaints for up to one (1) year from the date of service or incident. If we receive your complaint after one year, within 30 calendar days we will send you a letter explaining that we received your complaint late, or untimely. You can send us your information to file a complaint by postal mail or fax. We may ask you to send supporting documentation so we can investigate your concern as thoroughly as possible. It’s also 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 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.

**MEMBER COMPLAINTS**

By definition, a complaint is any expression of dissatisfaction. You have 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 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. Based on guidelines from the state, we accept member complaints for up to 30 days from the date of service or incident.

We’ll acknowledge receipt of the grievance in writing within five days. We’ll send a copy of the letter to the member and to their representative, if there is one. We may ask you to send supporting documentation so we can investigate the member’s concern as thoroughly as possible. When we finish reviewing your 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 make a decision 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 also have the right to file a complaint about a decision we make about a complaint 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. 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.

On request, we assist members who want to file a complaint or an appeal. We also have a toll-free number, 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 provide 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 Appeal Process**

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. The provider appeal is the process you should use if you have a dispute with a claim we failed to reimburse or reimbursed at less than the amount you expected. An appeal is also the process to use for a request for authorization of a service that we denied or did not respond to within a reasonable time. Finally, you can file an appeal if you are dissatisfied 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.

It is often helpful to your case if you clearly explain that you are filing an appeal and provide supportive documentation. You should use facts to explain why we should make a decision in your favor. 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  
Attention: Complaint and Appeal Department  
9900 Corporate Campus Drive, Suite 1000  
Louisville, KY 40223

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

Within 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
We're 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 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**

Attention: Complaint and Appeal Department
9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

If you wish to fax your request, our fax number is 1-844-359-6670. To submit your request electronically, email KYSecondLevelAppeal@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 your designated contact person a letter within five (5) business days of the day we received your letter. We’ll notify the Department for Medicaid Services 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.

**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, you can file an appeal for a member. The state guideline says this written permission has to 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 can file an appeal for the member and
  - Specifically notes what you are appealing

We’ll let the member and their representative know we received the appeal within five business days after we receive the appeal. We will make a decision on the appeal and send a letter to let you know the decision within thirty calendar days of the date the appeal was received. 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.

You have a right to request and receive a written copy of the criteria, policy, or procedure we used to make your appeal decision if your case was about a clinical decision. No punitive action or retaliation will be taken towards a member or provider for filing an appeal or complaint. Also, we will never discriminate against a member or provider for filing a complaint or appeal.

**EXPEDITED APPEALS**

We have a fast process for working through member appeals when waiting the usual period for a decision could cause harm to the member. We can only approve a member’s request for expedited processing if:

- The life or health of the member could be endangered by waiting 30 days
- The life or health of a pregnant member’s unborn child could be endangered by waiting 30 days
- Waiting for a standard 30-day decision could negatively affect the member’s ability to attain, maintain or regain maximum function

To request an expedited appeal, you can call us. Your request for an expedited appeal doesn’t have to be submitted in writing. Our phone number is **1-855-300-5528** (TTY users dial 711/TDD users dial 1-800-627-4702). We are open Monday through Friday. Our hours are 7a.m. to 7p.m. ET. If your request for an expedited appeal meets the above guidelines, we won’t require you to provide written consent from the member. We’ll make a decision within 72 hours. In some cases, we may make a decision even earlier if the member’s physical or behavioral health requires a faster decision. For this reason, any additional information the member or representative wishes to be reviewed with the appeal must be submitted within 24 hours of the time the appeal is submitted for expedite requests. 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 an appeal or complaint.
STATE FAIR HEARING

If a member is unhappy with the outcome of their appeal, they may request a State Fair Hearing. We advise members of their State Fair Hearing rights when we send them any denial letter. Like with appeals and complaints, a member may choose anyone they wish to act on their behalf for the purposes of a State Fair Hearing. Members or their representative have 45 days from the date of the last decision letter they received to ask for a hearing. To request a State Fair Hearing, the representative or member should send a letter to the address below:

Kentucky Department for Medicaid Services  
Division of Program Quality and Outcomes  
Attention: State Fair Hearings  
275 East Main Street, 6C-C  
Frankfort, KY 40621-0001

To qualify for a State Fair Hearing, the letter should:

- Be mailed or filed within 45 days from the date on the most recent decision letter we sent the member
- Explain why a State Fair Hearing is needed
- Give the date of service and kind of service we denied
- Include a copy of the last appeal decision letter we sent

MEMBER INQUIRY

There may be times when a member has questions. A member inquiry is when a member calls us for information. The member may want to understand our policies better or they might ask that we explain benefits. Other questions could involve specific procedures or any other aspect of our business. If, at any time during the call, the member expresses dissatisfaction, the issue will be labeled as a complaint. Member Services handle all member inquiries. Member Services can be reached at 1-855-300-5528 (TTY users dial 711/TDD users dial 1-800-627-4702). We are open Monday through Friday. Our hours are 7a.m. to 7p.m. ET.

CLAIM REVIEWS

A claim review is a verbal or written request to research a denial, a claim paid incorrectly, claim bundling issues, or a decision we made. Types of claims issues that should go through claim review include but are not limited to:

- Denials for timely filing when you have proof that you filed on time
- Denials for no authorization when you have an authorization (except in the case of a retroactively terminated member)
- Coding issues such as bundling, mutually exclusive, etc.
- Duplicate denials when there was an additional service
- Claim not paid according to your contract
- Coordination of benefits issues

If you label your request as an appeal or complaint, or if you send it to the Appeals Department, it may take longer for us to process it. If you believe we paid a claim incorrectly, based on the contracted rate in your Agreement with us, let us know. We will correct miscalculations once we confirm there is an error. There are several ways you can file a claim review. You can:
• Call the claims department at **1-855-300-5528**
• Write to the claims department at:

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

Mark the claim as “corrected” or “resubmittal”. Be sure to include all supporting documentation.

For claim issues, the claim review is the fastest way to get payment for your claim. Claim reviews filed in writing may be resolved in 30 days or less. Before filing a complaint or appeal on a claim issue, we suggest that you try to solve the claim issue using the claim review. You have 24 months from the date you received the payment on the claim to submit claim payment errors for review.

When you receive a request for additional information (invoice, itemized billing, medical records, etc.) on your claim remit, forward the information directly to:

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

If you feel that the claim review did not work for you, you can file a complaint or an appeal. Make sure to submit all your supporting documentation, including any information you already gave to the claims department.

**PROCESS DEFINITIONS AND TIMEFRAMES**

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.

<table>
<thead>
<tr>
<th>Process definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Grievance (complaint)</td>
</tr>
<tr>
<td>Appeal</td>
</tr>
</tbody>
</table>
### Process definitions

<table>
<thead>
<tr>
<th>Process</th>
<th>Definition</th>
<th>Determination timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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 an appeal letter in writing to complete the appeal request. Without the appeal letter, we’re unable to open the case.</td>
<td>frame 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</td>
</tr>
</tbody>
</table>
Section 11 - Fraud 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 www.aetnabetterhealth.com/Kentucky, or upon request to your provider relations representative. In addition, more information about the DRA and these requirements are available for your review on the CMS website www.cms.hhs.gov.

**HOW TO REPORT FRAUD AND/OR ABUSE**

If you believe you have information relating to health care fraud, abuse or waste, please contact our special investigation unit (SIU). The SIU will review the information provided and will maintain the highest level of confidentiality as permitted by law. You may contact our SIU by calling 1-866-806-7020.
SECTION 12 - HIPAA

HIPAA

PRIVACY RULE
The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. It was created to assure health insurance protections and portability for individuals changing jobs. In addition, it enforces standards for electronic submission of health information and provides security and privacy of health information to protect the confidentiality and integrity of individually identifiable health information, commonly called Protected Health Information (PHI). Under HIPAA, PHI may be communicated for treatment, payment, and health care operations. HIPAA also mandates the use of standard codes and the appropriate use of those codes.

Aetna Better Health has a functional privacy program in place. Providers must identify themselves by their tax identification number (TIN) and/or National Provider Identifier (NPI) Number in all telephone conversations with Aetna Better Health. Aetna Better Health adheres to the minimum necessary requirement of the rule and the de-identification of PHI when appropriate.

Please call our compliance officer at 1-888-470-0550, if you have further questions.

PROTECTED HEALTH INFORMATION (PHI)
To remain compliant with HIPAA, Aetna Better Health uses some business practices which may affect our provider communities with regard to Privacy and transactions and code sets. These modifications are outlined in this document.

DELEGATED CREDENTIALING, UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT ACTIVITIES AND PROTECTED HEALTH INFORMATION (PHI)
In the event that Aetna Better Health delegates credentialing, utilization management or Quality Improvement functions to a provider (the “Delegate”) and such delegation arrangement includes the use of protected health information (PHI) by the Delegate, the following shall apply:

Delegate may use and disclose protected health information and non-public personal information (collectively PHI) in its possession for its proper management and administration and/or to fulfill any present or future legal responsibilities of the Delegate, provided that such uses are permitted under state and federal laws and would be permissible if performed by Aetna Better Health. Delegate represents and warrants to Aetna Better Health that (i) any such disclosures it makes will be required by law and (ii) the Delegate will obtain a written agreement from any such person or entity to whom the PHI will be disclosed that the PHI will be held confidentially and will not be further used or disclosed except as required by laws or for the purpose for which it was lawfully disclosed to such person or entity, and that such person or entity will notify the Delegate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

Delegate agrees to the following:

- Delegate shall not use or further disclose the PHI other than as permitted under this Agreement, HIPAA, Gramm-Leach-Bliley Act (GLBA), The American Recovery and Reinvestment Act of 2009 (ARRA) and their respective implementing regulations, each as amended from time to time.

- Delegate shall (i) use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for in this Agreement, and (ii) have administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of Aetna Better Health. Such safeguards shall include,
without limitation, conducting a security risk assessment, and training employees who will have access to PHI with respect to the policies and procedures required by HIPAA and ARRA. Upon request from Aetna Better Health, Delegate shall provide Aetna Better Health with a copy of its written information privacy and security programs.

- Delegate shall adopt and comply with policies and procedures that are in accordance with the HIPAA, ARRA, and GLBA requirements that apply to Delegate’s operations and the Services provided under the Agreement, including without limitations, maintaining the confidentiality and integrity of any information received, maintained or transmitted by or on behalf of Aetna Better Health. Upon Aetna Better Health’s request, Delegate shall provide a copy of Delegate’s policies and procedures.

- Delegate shall report to Aetna Better Health any security incident involving or use or disclosure of PHI not permitted by this Agreement of which it becomes aware. Delegate shall report to Aetna Better Health within five (5) days of the Delegate becoming aware of such use, disclosure or incident.

- Delegate shall report to Aetna Better Health within five (5) days any Breach of Unsecured PHI. “Breach” shall mean the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of such information. “Unsecured PHI” shall mean PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary from time to time. Notice of Breach shall include, at minimum: (i) the identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the Breach; (ii) the date of the Breach, if known; (iii) the scope of the Breach; and (iv) a description of the Delegate’s response to the Breach. Upon reasonable request, Delegate shall provide Aetna Better Health with information related to the Breach and will cooperate with Aetna Better Health in any required notifications.

- To the extent that Delegate provides services to Aetna Better Health relating to individuals enrolled in state or federal programs (i.e., Medicare, Medicaid), Delegate shall comply with any additional restrictions or requirements related to the use, disclosure, maintenance, and protection of PHI of individuals enrolled in such programs through Aetna Better Health. With respect to the PHI of Medicaid enrollees, Delegate shall report privacy and security incidents and/or Breaches immediately, but not later than one (1) day, to Aetna.

- Delegate shall require any agent or subcontractor to whom Delegate provides PHI to agree in writing to (i) implement reasonable and appropriate safeguards to protect the PHI, and (ii) comply with the same restrictions and conditions on PHI as required by this Agreement. Upon request from Aetna Better Health, Delegate shall provide a copy of any such agreement.

- Delegate shall require, use and/or disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

- Delegate shall not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. 17935(d) and any regulations promulgated there under.

- Delegate shall not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. 17936(a) and any regulations promulgated there under.

- Delegate shall not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. 17936(b) and any regulations promulgated there under.

- Delegate shall mitigate, to the extent reasonably practicable, any harmful effect that is known to delegate as the result of a use or disclosure of PHI by delegate that is not permitted by this Agreement.

- Delegate shall not use, transfer, transmit, or otherwise send or make available, any PHI outside the territory of the United States of America without Aetna Better Health’s prior written consent.
• The Delegate shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members less than eighteen (18) years of age pursuant to Title X. 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et seq., KRS 202A, and KRS 214.185.

• The Delegate shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.

CONTACTING AETNA BETTER HEALTH OF KENTUCKY BY PHONE
Your staff will be asked to provide your TIN and/or NPI number, in addition to identifying member demographic information, as part of our caller authentication process.

EMAILING PROTECTED HEALTH INFORMATION
Due to privacy and security considerations, Aetna Better Health has a policy to not transmit PHI by unencrypted email over an open network (i.e., standard email). If PHI must be transmitted by email due to certain circumstances, Aetna Better Health has a secure message system allowing electronic personal health information (EPHI), to be transmitted. When EPHI is transmitted to an outside party from Aetna Better Health, the outside party must open the link to the email and create a password to open the message containing personal health information.

PERSONAL REPRESENTATIVE
Aetna Better Health will allow personal representatives (those individuals that have been granted legal authority under state law) to assist members by acting on their behalf and accessing their personal health information.

MEMBER DESIGNATED INDIVIDUALS
Members may also provide written permission to have one (1) or more member designated individuals to assist in the handling or resolving questions regarding health care benefits or payments. The Aetna Better Health systems maintain this information and all member-designated individual calls will be subject to the caller authentication processes.

CLAIMS INQUIRIES
Aetna Better Health representatives will not divulge the diagnosis billed on a claim to either the member or provider. Any member questions related to diagnosis will be re-directed to their provider. In addition, any provider’s office requesting diagnosis or procedure code information from the submitted claim will be asked to contact their billing office.

PROVIDER COMPLAINTS AND APPEALS
Regardless of the type of appeal (written, expedited, or peer-to-peer reviews), both our organization and the provider office should exchange the minimum amount of individually identifiable health information necessary to process the review or appeal.

AUDITS OF MEMBER’S MEDICAL RECORDS
On an ongoing basis, we conduct quality improvement (QI) activities as required for licensure and reporting requirements. We also conduct utilization management (UM) activities to provide the best quality service to our
members. As part of our QI and UM processes, Aetna Better Health performs periodic quality reviews and requests medical information.

These requests include the review of randomly selected medical records for members that are, or have been members of Aetna Better Health.

The disclosure of PHI by providers to Aetna Better Health and the Aetna Better Health quality review of medical information maintained by providers are permissible under the HIPAA Privacy Rule. Aetna Better Health will only make requests as allowable under the Privacy Rule of HIPAA. We will also only request the minimum amount of information necessary to accomplish the task at hand.

**EDI TRANSACTIONS**

Aetna Better Health continually strives to meet the transaction and code set provisions of HIPAA’s Administrative Simplification. Aetna Better Health has implemented the x12N v5010 mandated transactions and code sets. Aetna Better Health has certified the transactions are HIPAA compliant using See Beyond (an enterprise integration system) and Claredi (a third party certification service).

**CODE SETS**

Updates are made regularly to comply with standard code sets. HIPAA requires that payers and clearinghouses reject electronic claims with non-standard codes. Any paper claim submitted with non-standard coding will be processed with a denial disposition description and returned to the provider. These claims should be worked by the provider within the timely adjusted period, and resubmitted in the same manner, either electronically or via paper.

**Access to PHI**

Within five (5) days of a request by Aetna Better Health for access to PHI about an individual contained in a Designated Record Set (as such Set is then defined by HIPAA regulation), the Delegate shall make available to Aetna Better Health, or the individual to whom such PHI relates or his or her authorized representative, such PHI for so long as such information is maintained in the Designated Record Set as set forth in 45 C.F.R. § 164.524. In the event any individual requests access to PHI directly from the Delegate, the Delegate shall, within five (5) days, forward such request to Aetna Better Health. Aetna Better Health shall be responsible for determining whether to deny access to the PHI and Delegate shall comply with such determinations.

**DISPOSITION OF PHI AT TERMINATION**

Within 30 days of the termination of the Delegate, the Delegate and its subcontractors, will return or destroy all PHI received from, or created or received by the Delegate on behalf of Aetna Better Health, which the Delegate and/or its subcontractors or agents still maintain in any form, and will not retain any copies of such information. If such return or destruction is not feasible, the Delegate will notify Aetna Better Health of the reasons for such in writing. Delegate shall extend the protections, limitations and restrictions of the PHI retained after the termination and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
**Section 13 - State and Federal Programs Requirements and Services**

**Communicable Disease Reporting**
Provider is required to comply with any applicable communicable disease reporting requirements.

**Physician Incentive Program (PIP) Regulations**
The federal Physician Incentive Program regulation is designed to protect beneficiaries enrolled in Medicare and Medicaid managed care organizations by placing certain limitations on provider incentive programs that could influence a physician’s care decisions.

On an annual basis and in compliance with this federal regulation, Aetna Better Health must disclose provider incentive programs to CMS and the Cabinet. The information to be disclosed shall include the following:

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

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

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

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

• Whether any risk is transferred (i) to the provider or provider group by Aetna Better Health, or (ii) to a provider or provider group by an IPA or another intermediate entity for referral services.

• What percent of total potential payment to the provider/provider group is at risk for referrals?

• What is the number of members included in the same risk arrangement if the number of members is 25,000 or fewer; what is the type and amount of stop-loss protection insurance?

• Whether the PIP puts providers/provider groups at “substantial financial risk.”

• If there is “substantial financial risk,” what is the amount of stop-loss protection required and how is the survey requirements met?

**HOW CAN PROVIDERS AND SUBCONTRACTORS COOPERATE WITH AETNA BETTER HEALTH?**

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

• Upon request, providers/provider groups will submit to Aetna Better Health all data necessary for Aetna Better Health to meet its PIP disclosure and reporting obligations in accordance with federal law and the Kentucky Medicaid contract. Providers/provider groups shall certify, in writing, the completeness, truthfulness, and accuracy of all such data.

• If any providers/provider groups are at “substantial financial risk” such providers/provider groups agree to obtain stop-loss protection as required by the federal regulations.

• Providers/provider groups shall cooperate with Aetna Better Health regarding the obligation of Aetna Better Health to conduct surveys of members in instances where a provider/provider group has indicated that it is at “substantial financial risk.”

**WHAT PAYMENTS ARE PROHIBITED?**

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

**WHAT INFORMATION MUST BE REPORTED TO CMS AND THE CABINET BY AETNA BETTER HEALTH?**

The disclosure requirements apply not only to Aetna Better Health’s direct contracting arrangements with providers, but to its subcontracting arrangements as well. In general, MCOs must provide to CMS information concerning their PIPs as may be requested by CMS. In addition, MCOs that contract with a provider group that places the individual provider members at substantial financial risk (SFR) for services they do not furnish must disclose any incentive plan between the provider group and its individual providers that bases compensation to the provider on the use or cost of services furnished to Medicare beneficiaries or Kentucky Medicaid recipients. Finally, when an MCO contracts with an intermediate entity such as an individual practice association (IPA) that, in turn, contracts with one or more provider groups and a provider hospital organization (PHO), the MCO must disclose to CMS any incentive plans between the intermediate entity and a provider or provider group that bases compensation on the use or cost of services furnished to Medicare beneficiaries or Kentucky Medicaid recipients.
**WHAT INFORMATION MUST BE REPORTED TO AETNA BETTER HEALTH MEMBERS?**
For Medicare or Kentucky Medicaid beneficiaries who request it, contracting MCOs must provide information indicating (i) whether the MCO or any of its contractors or subcontractors uses a PIP that affects the use of referral services, (ii) the type of incentive arrangement(s) used, and (iii) whether stop-loss protection is provided. If the MCO is required to conduct a survey, it must also provide beneficiary requestors with a summary of survey results.

**WHAT IS SUBSTANTIAL FINANCIAL RISK (SFR)?**
SFR occurs when the incentive arrangement places the provider or provider group at risk for amounts beyond the risk threshold, which is the maximum risk, if the risk is based on the use or costs of referral services. Risk threshold is set at 25% and does not include amounts based solely on factors other than a provider’s or group’s referral levels. Bonuses, capitation and referrals may be considered incentive arrangements that result in SFR.

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

**WHAT HAPPENS IF AN MCO OR A PROVIDER DOES NOT COMPLY WITH PIP REQUIREMENTS?**
Failure to comply with the PIP rule may result in application of intermediate sanctions, or imposition of civil money penalties, as described in 42 CFR §417.500 and 42 CFR § 434.67. CMS may also withhold Federal Financial Participation from the state if the state or an MCO fails to fulfill State Plan or contract requirements, respectively.