KANCARE
MCOs MEDICAL MANAGEMENT
Prior-Authorization/Notification Guide
For Participating Providers
April 6, 2020 Final Version

Note: This is a summary guide regarding prior authorization/notifications. Please note the terms of your provider contract and provider manual. This list is not all-inclusive. Failure to obtain the required prior approval or pre-certification may result in a denied claim(s). All services are subject to eligibility, benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

All Out of Network (Non-Par) services require prior authorization, excluding ER, urgent care and family planning.

(UnitedHealthcare - Non-par providers are required to obtain a PA for all services they provided to our members effective 10/1/19. The only exclusion are ER, urgent care, and family planning.

Prior Notification and Authorization	Aetna Better Health of Kansas	Sunflower Health Plan	UHC
Inpatient (IP):			
IP Criteria	MCG	Interqual	MCG
IP Elective	Authorization will be determined within 14 calendar days from receipt of request.	Authorization will be determined within 14 calendar days from receipt of request.	Authorization will be determined within 14 calendar days from receipt of request.
IP Elective Expedited (must document or advise "Expedited")	Authorization will be determined within 72 hours from receipt of request.	Authorization will be determined within 72 hours from receipt of request.	Authorization will be determined within 72 hours from receipt of request.
IP Emergent (includes if direct admit through ER)	Notification within 48 hours of admission or the next business day.	Notification within 1 business day of admission.	Notification within 48 hours of admission or the next business day.
IP Hospice (hospice provider completes Authorization)	Prior Authorization is not required.	Authorization determined within 3 calendar days of admission.	Prior Authorization is not required.
IP Long Term Acute Care (LTAC) Hospital (LTAC provider completes authorization)	Authorization will be determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information, however since these are almost exclusively transfers from acute care setting, determination to transfer will be made in the same manner as an "expedited" case.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information, however since these are almost exclusively transfers from acute care setting, determination to transfer will be made in the same manner as an "expedited" case.
IP Rehab (rehab provider completes authorization)	Authorization will be determined within 72 hours from receipt of request.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information.

IP Rehab Expedited **(must document or advise "Expedited")**	Authorization will be determined within 72 hours from receipt of request.	Authorization will be determined within 72 hours from receipt of request.	Authorization will be determined within 72 hours from receipt of request.
IP Retro Review	Only If extenuating circumstances. MCOs recommend always confirming if uninsured individuals are covered by checking KMAP site. Retro-authorization resulting from member retro-eligibility must be requested prior to submitting a claim in order for the claim to not deny. If the claim is submitted prior to the authorization request, the claim will deny and the provider will need to submit an appeal with medical records. **Examples of these cases include:** • Patient receives retro eligibility into KanCare	Only if extenuating circumstances. MCOs recommend always confirming if uninsured individuals are covered by checking KMAP site. Authorizations will not be denied based off of normal notification timelines in retro eligibility cases. **Examples of these cases include:** • Patient receives retro eligibility into KanCare	Within 30 days of admission unless Prior Authorization is required. MCOs recommend always confirming if uninsured individuals are covered by checking KMAP site. **Examples of these cases include:** • Patient receives retro eligibility into KanCare • Mother presents with commercial insurance and it is assumed newborn is on mom's insurance. Normal newborn is determined to be eligible with UHC after discharge
OB	**Mom:** Notification within 48 hours of admission or the next business day**.** **Baby:** Notification within 48 hours of delivery or the next business day, including delivery outcome.	**Mom:** Notification within 1 business day of delivery, for normal delivery. **Baby:** Notification within 1 business day of delivery, including delivery outcome.	**Mom:** Notification within 48 hours of admission or the next business day. **Baby:** Notification within 48 hours of delivery or the next business day, including delivery outcome.
Outpatient (OP):			
OP Hospice **(hospice provider completes authorization)**	Prior Authorization is not required.	Limited codes require an authorization. Those will be determined within 14 business days from receipt of request.	Prior Authorization is not required.

High Tech Imaging Expedited Request **High Tech Imaging**	PA request will be determined by eviCore, within 72 hours when submitted with complete clinical information. Standard PA request will be determined by eviCore, within 14 calendar days from receipt of request when submitted with complete clinical information. High Tech Imaging is defined as MRIs, MRAs, CT Scans, and PET Scans (not covered by KanCare).	PA request will be determined by NIA, within 72 hours when submitted with complete clinical information. PA request will be determined by NIA, within 14 calendar days from receipt of request when submitted with complete clinical information. LTC Nursing Facility Custodial Members please obtain Prior Authorization from Sunflower.	Effective 05/02/14 PA is no longer required with the exception of PET scans (PA will still be required as this is a non-covered service). High Tech Imaging is defined as MRI, MRA's, and SPECT MPI.
OP Therapies PT/OT/ST (OP Only)	Prior Authorization is not required.	Effective 6/1/20, PA is managed by NIA. PA required for waiver therapy codes and in-home services thru Sunflower Health Plan.	Effective 05/02/14 PA is no longer required.
Infusion Therapy	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.
Cardiac Rehab	Prior Authorization is not required.	Prior Authorization is not required.	Prior Authorization is not required.
Home Health	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request when submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.
Observation	No prior authorization required.	No prior authorization required.	No prior authorization required.
Long-term care (LTC) - Custodial	No prior authorization required.	No prior authorization required.	No prior authorization required.

Long-term Care (LTC) - Skilled	Authorization will be determined within 72 hours from receipt of request when submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request when submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information. **Expedited:** Authorization determined within 72 hours from receipt of request submitted with complete clinical information. Please note: PA required only if the provider bills services using revenue code 120. Services billed using revenue codes 101 do not require a PA.
Skilled Care – Swing Beds	Swing bed within an acute care facility requires authorization. Authorization will be determined within 72 hours from receipt of request submitted with complete clinical information.	Authorization will be determined within 14 calendar days from receipt of request submitted with complete clinical information.	PA required only if the provider bills swing bed services using revenue code 120. Services billed using revenue code 101 does not require a PA.
Retro-Eligible Authorization Review Process with claim not submitted	These claims should be stopped and reviewed at the time of processing to avoid denials. If a claim does deny due to no PA due to retro-eligibility, please work with your Aetna Better Health network relations manager. Those claims will be allowed without PA or medical records.	Prior authorization is not required if member has already been discharged before date of eligibility determination.	These claims should be stopped and reviewed at the time of processing to avoid denials. If a claim does deny due to no PA due to retro-eligibility, please work with your provider advocate. Those claims will be allowed without PA or medical records.
Retro-Eligible Authorization Review Process with claim submitted	These claims should be stopped and reviewed at the time of processing to avoid denials. If a claim does deny due to no PA due to retro-eligibility, please work with your Aetna Better Health network relations manager. Those claims will be allowed without PA or medical records	Prior authorization is not required if member has already been discharged before date of eligibility determination. Sunflower Health Plan my request a post payment review.	These claims should be stopped and reviewed at the time of processing to avoid denials. If a claim does deny due to no PA due to retro-eligibility, please work with your provider advocate. Those claims will be allowed without PA or medical records.

Retro-Eligible Authorization Review Process for Normal Newborns	No authorization will be required for normal newborn stays with a length of stay less than 2 days for vaginal delivery and 4 days for cesarean delivery.	No authorization will be required for normal newborn stays with a length of stay less than 4 days. Timely notification policies will still apply.	No authorization will be required for normal newborn stays with a length of stay less than 4 days **IF** the primary ICD-CM procedure code is in the following range 7200 – 7499 or 7540 – 7592.
Electronic Notification Options: • **N278** • **Daily Census**	 Hospitals may fax the daily IP census report to Aetna Better Health: Fax#: 1-855-225-4113	 Hospitals may fax the daily IP census report to SHP: Fax #: 1-866-965-5433	We can accept this from some vendors. We continue to work with additional vendors. Please let us know if there are any concerns. Contact: Carrie Kimes ckimes@uhc.com
Transportation **Emergent** **Non-emergent** **Transfer**	 No PA required. Provided by Access2Care. Please call: 1-866-252-5634. No PA required.	 No PA required. PA required for non-emergent fixed wing transport. Providers must utilize Logisticare, our NEMT transportation vendor, if a member does not require transport by EMS/Ambulance. Services provided by Logisticare do require PA, but can be requested on the same day. Transportation should be provided within 3 hours of a confirmed request.	Provided by EMS/Ambulance providers No PA required. No PA required. No PA required. Providers must utilize Logisticare, our NEMT transportation vendor, if a member does not require transport by EMS/Ambulance. Services provided by Logisticare do require PA, but can be requested on the same day. Transportation should be provided within 3 hours of a confirmed request.
If Medicaid is secondary to Medicare or Commercial	PA not required if a member had Medicare or Commercial insurance as the primary payer.	PA not required if a member had Medicare or Commercial insurance as the primary payer.	PA not required if a member had Medicare or Commercial insurance as the primary payer.
Behavioral Health Authorization	BH outpatient requests should be faxed to 1-855-225-4102 BH Inpatient requests should be faxed to 1-855-225-4113 SED waiver authorization requests should be requested through the members assigned Service Coordinator. Providers may also call: 1-855-221-5656.	Services requests should be faxed to 1-844-824-7705. Until 7/1/2020 - SED waiver services are guided by the POC and submitted through KAMIS or faxed to 1-844-824-7705. After 7/1/2020 – SED waiver services are guided by the PCSP that is completed by the MCO.	BH inpatient and outpatient requests should be faxed to 1-855-268-9392. SED waiver authorization requests should be submitted through KAMIS, and SUD authorization requests should be submitted through KCPC. Providers may also call: 1-855-802-7095.

Submit Authorization Request by:			
Fax:	**Outpatient Medical/Behavioral Health Services:** 1-855-225-4102 **Inpatient Medical/Behavioral Health Services:** 1-855-225-4113 You may enter and verify authorizations through the Secure Provider Portal at www.aetnabetterhealth.com/kansas	**Inpatient/Outpatient Services:** 1-888-453-4316 You may enter and verify authorizations through the Secure Provider Portal at SunflowerHealthPlan.com	**Inpatient/Outpatient Medical Services:** 1-866-943-6474
Phone:	**Medical & Behavioral Health:** 1-855-221-5656	**Medical/Behavioral:** 1-877-644-4623	**Medical and Behavioral:** 1-877-542-9235
Long-Term Care/Long Term Support Services (LTC/LTSS) Contacts for Plan of Care (POC) change request	For prior authorization of HCBS Services, contact the member's Service Coordinator, or call 1-855-221-5656.	**LTC/LTSS:** 1-877-644-4623 For prior authorization of HCBS Services, contact the member's Care Manager, or the number listed above.	Contact our provider services call center at 1-877-542-9235 and request to speak to the LTCC Clinical Coordinator in regards to a Plan of Care change request.
Secure Website Portal:	www.aetnabetterhealth.com/kansas **Outpatient High Tech Imaging: eviCore** www.evicore.com	www.sunflowerhealthplan.com **Outpatient High Tech Imaging:** www.radmd.com	https://www.uhcprovider.com