Who do I call if I have a question regarding a claims denial?

The Customer Services Department is available to assist with denial questions about claims. The number is 1-800-399-7524.

What fee schedule does Kansas Health Advantage use to pay providers?

Kansas Health Advantage is a product of American Health Plans, Inc. (AHP), a Medicare Advantage organization that holds a Medicare contract to provide these services in several states. AHP uses the current Medicare fee schedule for the state where the services are rendered.

Can a medical provider dispense DME items?

If a medical provider is a licensed DME supplier and is contracted with Kansas Health Advantage to supply DME, the provider may dispense DME items. Please see Prior Authorization DME requirements in the Quick Reference Guide. In addition; Prior Authorization is required for All DME items greater than $250 billed charges per month. Contact the Care Management Department at 800-399-7524 with Authorization requests for any DME.

Is there an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy like Medicare?

Kansas Health Advantage does not have an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy. Benefits are based on medical necessity and Prior Authorization is required. Contact the Care Management Department at 1-800-399-7524 with Authorization requests.

How often are participating providers required to be re-credentialed?

Participating provider are required to get re-credentialed every three years.

How will I know when my new provider has been credentialed?

The credentialing process includes final approval from the Medical Advisory Committee (MAC). Upon completion of the process, a letter is sent advising the provider of his/her acceptance into the network.

What fields on the claim forms are the NPI numbers supposed to be entered?

- The individual provider's NPI number goes in Box 24J on the CMS 1500.
- The group NPI number goes in Box 33A on the CMS 1500.
- The attending physician's NPI number goes in Box 76 on the UB-04.
- The operating physician's NPI number goes in Box 77 on the UB-04.

How does Kansas Health Advantage determine if non-emergency ambulance transportation is covered?

Kansas Health Advantage uses Medicare guidelines to determine if a non-emergency Ambulance transportation meets medical necessity. All non-emergent transports require prior Authorization. Please contact the Care Management Department at 1-800-399-7524 with Authorization requests.

Can I bill the patient if my payment from Kansas Health Advantage was not what I anticipated?

The member should not be billed any more than the copay, coinsurance or deductible. Please note that copays, coinsurance and deductible amounts for dual eligible members should be billed to the appropriate state Medicaid program. If you believe the payment is inconsistent with the current Medicare fee schedule or the denial reason is incorrect, please submit a Claims Reconsideration with the appropriate documentation to support your belief. You may also call your local Network Services Representative for further explanation.

What should I do if I bill Medicare, the claim is denied, and I find out the member had Kansas Health Advantage at the time of service, but timely filing has passed?

If a claim has not been filed, please file the claim. Once the denial is received, submit a Claims Provider Dispute Resolution form along with supporting documentation as evidence that your initial verification showed that the member had Medicare. Also, submit a copy of the Explanation of Medicare Benefits (EOMB) for purposes of determining Timely Filing. The claim must be filed within 120 days of the Medicare denial to meet the Timely Filing deadline.

Who is available from the Plan to educate on proper processes to handle an Authorization?

Your KHA Network Services Representative will provide education regarding internal communication and how to send any supporting documentation for Authorization determinations within CMS requirements.

What are the requirements to assist the assigned member's Care Management team to ensure timely processing of Authorization request?

The Nursing Home Staff is responsible for sending information to the Care Manager to support an Authorization?

The required documentation for a complete Authorization request or available in the Member's Electronic Health Record:

- A supporting order
- The appropriate information to submit a completed Authorization request form
- The appropriate supporting clinical documentation for the services being requested.
- Any initial Authorization documentation not in the Electronic Health Record should be submitted to the Health Plan via a secure fax, no emails allowed.

What is the typical response time after an Authorization request has been submitted?

The goal time to respond is 72 hours. Any incomplete information to complete the Authorization request, will likely delay the response time.

What happens if the information for the Authorization is not complete?

The UM Department would notify the Health Plan Care Manager that the information is incomplete to process the Authorization request. The Care Manager would then contact the Facility for additional supporting documentation and resubmit. Once a completed Authorization request and supporting documentation is received by the Health Plan's UM Department the goal response time would be 72 hours from the corrected submission.

Why does the Health Plan require submission via secure fax number?

- Secure fax number submission protects Members Protected Health Information (PHI)
- Allows any and all members of the Care Management team has access to the information.
- Prevents and delays when primary Care Manager is not available.

Why is the Facility responsible for gathering supporting documentation for concurrent Authorization reviews?

- The Health Plan does not perform utilization review at the facility level.
- Care Management team members are not licensed therapist or MDS Coordinators with specialized education to make medical necessity determinations for all Authorization request at the Facility level.
- Care Management team may not have or be allowed access to medical records of third-party vendors.
- It allows the Facility to actively collaborate with the Health Plan in the determination process.

How are Authorizations communicated back to the Facility?

- The determination letter is sent to the Care Manager from the Health Plan.
- It is the UM Department and Care Manager's shared responsibility to communicate determinations within CMS guidelines.
- The Care Manager will notify the Facility and servicing Provider of the determination.