In an attempt to clarify and outline the current State of Kansas (SOK) Autism pilot benefit, listed below you will find the SOK employee benefit rider for Autism services.

**Autism Rider**

This rider outlines the coverage provided for treatment of autism in covered children under the age of Nineteen (19).

Unless otherwise specified all other provisions of the Benefit Description apply to benefits outlined in this Autism Rider, including deductibles, copays, coinsurance, network provider arrangements and prior authorization.

**Definitions:**

**Autism Spectrum Disorder:** means the following disorders within the autism spectrum:
- Autistic disorder,
- Asperger’s syndrome, and
- Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS),

as specified within the diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR), of the American psychiatric association.

**Applied Behavior Analysis (ABA):** means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

**Autism Specialist:** means a person who:
- Has at least a masters degree in human services or education or fully Board Certified Behavior Analysis; and
- Maintains all standards, certifications, and licenses required for their specific Professional field; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 2,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and
- Is a Medicaid Enrolled Provider

**Comprehensive Assessment:** means completion (by an appropriate professional) and submission of results of:
- A Vineland II Survey Interview Adaptive Behavior Scales by an qualified evaluator who is a level 3 user based on the Pearson Assessments; and
- An IQ Test (optional); and
- A Neurological evaluation by a medical doctor to rule-out primary neurological disorder;
and
- A lead poisoning assessment; and
- A Speech Assessment to rule-out primary speech disorder; and
- A Hearing Assessment to rule-out primary hearing disorder; and
- DSM-IV Diagnostic Criteria; and
- An Assessment by one of the following:
  - Checklist for Autism in Toddlers (CHAT); or
  - Childhood Autism Rating Scale (CARS); or
  - Modified Checklist for Autism in Toddlers (M-CHAT); or
  - Screening Tool for Autism in two-year olds (STAT); or
  - Social communication Questionnaire (SCQ) (recommended for children four-years of age or older); or
  - Autism Behavior checklist (ABC); or
  - Gilliam Autism Rating Scale (GARS); or
  - Autism Diagnostic Observation Scale (ADOS); or
  - Autism Diagnostic Interview – Revised (ADI).
  - Autism Spectrum Screening Questionnaire (ASSQ); or
  - Childhood Asperger Syndrome Test (CAST); or
  - Krug Asperger’s Disorder Syndrome (ASAS); or
  - Australian Scale for Asperger Syndrome (ASDS); or
  - Asperger Syndrome Diagnostic Scale (ASDS).
  - Pervasive Developmental Disabilities Screening Test (PDD-ST).

**Intensive Individual Service Provider:** means a person who:
- Has at least a bachelors degree in human services or education; and
- Maintains all standards, certifications, and licenses required for their specific license/certification; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 1,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and
- Adheres to the DBHS/CSS training and professional development requirements; and
- Is a KMAP Enrolled Provider for intensive individual supports; and
- Works under the direction and supervision of an Autism Specialist.

**Periodic Assessment:** means an evaluation that shows an assessment of the improvement in the individual based upon the diagnosis and approved treatment plan. Timing of the periodic assessments will be based upon the treatment plan, but no less than every six months. Statistically significant improvement in the stated goals and objectives of treatment must be achieved to authorize continued treatment. A Vineland II Survey will be required on at least an annual basis. An annual IQ test is optional.

**Treatment Plan means:** A submission by a provider or group of providers and signed by both the provider(s) and parent(s)/caregiver(s) that includes:
- the type of therapy to be administered and methods of intervention,
• the goals, including
  o specific problems or behaviors requiring treatment
  o frequency of services to be provided
  o frequency of parent or caregiver participation at therapy sessions
  o description of supervision, and
• periodic measures for the therapy, including the frequency at which goals will be reviewed and updated,
• who will administer the therapy, and
• the patient’s current ability to perform the desired results of the therapy.

**Benefit Provisions:**

**Autism Spectrum Disorder (ASD):** Coverage is available for the diagnosis and treatment of ASD as defined. Diagnosis shall be the appropriate listed assessment instrument from the listed options, performed by an appropriately licensed medical provider. Benefits must be pre-approved by the Plan and may include Applied Behavioral Therapy, developmental Speech Therapy, developmental Occupational Therapy, or developmental Physical Therapy as appropriate. Periodic re-evaluations and assessments are required and continuous improvement must be shown in order to qualify for continued treatment. Results of a Vineland II Survey will be required for the initial assessment to establish a baseline and must be repeated at least annually to establish improvement.

Services are limited as follows:

Coverage limits for Network and Non Network services combined:
- Children under age 7 limited to $36,000/year
- Children age 7-19 limited to $27,000/year
- Children age 19 and over, not covered

All services are subject to the applicable deductible, coinsurance and copay arrangements of the health plan. Providers will be reimbursed based upon network status.

All health claims with a diagnosis of Autism Spectrum Disorder will be subject to the limitations stated above.

Prior Approval: To qualify for this benefit, a comprehensive assessment may be required (see submission guidelines below). The treatment plan must be submitted to the Plan Administrator in advance of the initiation of treatment and outline measurable goals and objectives for treatment of the member. Benefits will be provided for the initial Comprehensive Assessment whether or not the member is approved for continued treatment. If approved for continued treatment, benefits will be available only for services received following the approval of the treatment plan.*

The provider must submit:

• For newly diagnosed members with eligible autism diagnosis, a Comprehensive Assessment must be completed and submitted within 90 days of treatment beginning under this rider.
• All members must have a treatment plan detailing the individuals who will be performing the various therapies and/or interventions and the type and frequency of the services to be performed. Services must be pre-approved by the health plan. Periodic Assessments must be submitted no less than every six months and include objective evidence of progress (a Vineland Survey).
Exclusions:

- Respite care
- Vocational rehabilitation
- Residential care
- Transportation
- Animal based therapy programs
- Hydro Therapy
- Camps
- Vitamin Therapy
- Programs and/or services administered within the Public, Private or Home School
- Vocational or Job training programs
- Services provided by relatives

To further clarify, all services by eligible CAP providers, i.e. speech pathologists, physical therapists, occupational therapists, MDs, DOs, etc. may be covered when submitted with an autism related diagnosis (299.00, 299.01, 299.80, 299.81, 299.90, 299.91) and will apply to the yearly coverage limitation.

These pilot benefits are applicable for State of Kansas employees only. Should you have additional questions regarding the SOK autism pilot, please contact New Directions Behavioral health at 1-800-952-5906.

*Prior approval requests must be submitted to New Directions Behavioral Health, P O Box 1627, Topeka, Ks. 66601-1627, OR can be faxed to NDBH @ 913-982-8176 in advance of the initiation of treatment under this plan.
**Important Contact Information**

**Customer Service Center (CSC)**

Questions regarding:
- Claim status
- Appeals
- Pre-determinations
- Benefits
- Eligibility

Contacts:
- E-mail: csc@bcbks.com
- 800-432-3980 or 785-291-4180
- Fax (new claims & dental precepts): 785-290-0786
- Fax (written inquiries, corrected claims and medical precepts): 785-290-0711
- Fax (all others): 785-291-8295

**CSC Providers Only Benefits Line**

Questions regarding:
- Benefits
- Eligibility

Contacts:
- E-mail: cso@bcbksa.com
- 800-432-0272 or 785-291-4183

**Professional Relations Hotline**

Questions regarding:
- Business procedures (option 1)
- Claim form completion (option 1)
- Claim status/adjustments (option 2)
- Coding (option 1)
- Credentialing (option 3)
- Network enrollment/contracting (option 3)
- Newsletter information (option 1)
- Policy manuals (option 1)
- Workshops (option 3)

Contacts:
- E-mail: prof.relations@bcbks.com
- 800-432-3587 or 785-291-4135
- (select option from list at left)
- Fax: 785-290-0722
- Wichita: 316-269-1874
- Wichita Fax: 785-290-0702

**BlueCard®**

Questions regarding:
- Eligibility for out-of-state members

Contact:
- 800-676-BLUE (800-676-2563)

**BlueCard®**

Questions regarding:
- Claim info for out-of-state members

Contact:
- 800-432-3990, ext. 4058

**Case Management**

Questions regarding:
- Assistance with coordination of care for patients with complicated health issues.

Contacts:
- 800-432-0216, ext. 6628 or 785-291-6628
- For FEP members: 800-782-4437, ext. 6511

**Federal Employee Program (FEP)**

All FEP inquiries except OPL

Contacts: 800-432-0379  •  785-291-4181  •  Fax: 785-291-7200

An Independent Licensee of the Blue Cross and Blue Shield Association.
Electronic Data Interchange (EDI)

Questions regarding:
- Electronic claims transmissions
- Electronic RA
- Billing software
- Clearinghouse services
- Web access and passwords

Contacts:
E-mail: askedi@ask-edi.com
Web site: www.ask-edi.com
800-472-6481
785-291-4178
Fax: 785-290-0720

Fraud Hotline

Questions regarding:
- Reporting of any illegal activity involving BCBSKS. Callers may remain anonymous.

Contacts:
800-432-0216, ext. 6400
785-291-7000, ext. 6400

New Directions

Questions for behavioral health care:
- Preauthorization
- Outreach services for high-risk patients
- Coordination with behavioral health care

Contacts:
800-852-5906
Fax: 813-982-8176

Other Party Liability (OPL) & Pre-Existing

Questions regarding:
- Duplicate coverage
- No-fault auto exclusion
- Subrogation
- Workers' compensation
- Pre-existing

Contacts:
800-430-1274
785-291-4013
OPL Fax: 785-291-8961

Pre-certification, Concurrent Review, and Alternate Care

Questions regarding:
- All hospital inpatient admissions

Contact:
800-782-4437

Teleorder

Contacts: 800-346-2227 or 785-291-8130

TRICARE

Questions regarding:
- Contracts
- Credentialing
- Network

Contacts:
E-mail: TriWest@bcbsks.com
800-432-3587 (option 4)
785-291-4138 (option 4)
Fax: 785-290-0734

Location Address:
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Billing Address:
P.O. Box 239
Topeka, KS 66601-0239
Claim Form

This form does not need to be completed if your services were provided by a contracting hospital, physician, or dentist. These contracting providers will file a claim on your behalf.

For prescription drug claims: File one claim per patient and attach an itemized bill from the pharmacy or the pharmacy receipts. Do not send cash register receipts. The proof of service must include patient's name, prescription name and prescription Rx number, NDC code, quantity, number of days supply, service date, cost for each prescription plus the complete name and address of the pharmacy.

For all other services: File one claim per patient and attach an itemized bill from the service provider. The itemization must include the patient's name, the service provided, service date, cost for each service and diagnosis. Please complete a separate claim form in full for each hospital and/or doctor bill being submitted.

Prompt filing of claims: Notice of your claim must reach Blue Cross and Blue Shield of Kansas within one (1) year and ninety (90) days from the date services were received. Submit this claim to Blue Cross and Blue Shield of Kansas, 1135 SW Topeka Boulevard, Topeka, KS 66609-0001.

Patient Name

Identification No. Group No.

Home Address

Home Phone No. Mobile Phone No.

Change of Address: If the address above is a different address, please check this box.

Alternate Payee Information: Please complete this section if someone other than the cardholder is to be reimbursed.

Alt. Payee Name

Alt. Payee Address

Alt. Payee Phone No.

Is this service related to an accident? Yes No If yes, complete the following:

Date of Accident

How did the accident occur?

Where did the accident occur? Home School Work Other

Was this injury/illness the result of occupational circumstances for which Workmen's Compensation is liable? Yes No

I Has a Workmen's Compensation claim been filed? Yes No If no, why not?

Please continue on other side.
Was the injury the result of physical contact with a motor vehicle?  ☐ Yes ☐ No  If yes, complete the following:

Type of motor vehicle involved ____________________________

If this was a motorcycle accident, do you have No Fault Motor Vehicle Insurance?  ☐ Yes ☐ No

Your auto insurance has a maximum dollar limitation on benefits payable for medical expenses. Please contact your auto insurance company and provide the following:

- Personal injury protection maximum dollar amount
- Excess medical benefits maximum dollar amount
- Complete itemized statement indicating provider of service, date of service and to whom paid.

Is patient entitled to benefits from any other group health insurance?  ☐ Yes ☐ No  If yes, complete the following:

Name of other insurance carrier ____________________________

Address of other insurance carrier ____________________________

Certificate or policy number ____________________________

Effective Date ____________________________ Cancellation Date ____________________________

Name of family member in whose name the policy is carried ____________________________

Name of employer of family member named above ____________________________

Is this patient entitled to benefits under Medicare hospital insurance (Part A)?  ☐ Yes ☐ No  If yes, effective date is ____________________________ ID# ____________________________

Name on Card ____________________________

Is this patient entitled to benefits under Medicare medical insurance (Part B)?  ☐ Yes ☐ No  If yes, effective date is ____________________________ ID# ____________________________

Name on Card ____________________________

Is this patient entitled to benefits under Medicare prescription drug insurance (Part D)?  ☐ Yes ☐ No  If yes, effective date is ____________________________ ID# ____________________________

Name on Card ____________________________

I represent that the information on this form is correct and that I am claiming benefits only for charges incurred by the patient named on this form.

Signature ____________________________ Date _________/_______/_______

If you have questions regarding this form, call:

Blue Cross and Blue Shield of Kansas  (785) 291-4180
Toll free: 1-888-552-3990

State of Kansas Employees  (785) 291-4185
Toll Free: 1-800-532-0367

To order additional forms, call Teleorder toll free at 1-800-546-2227, in Topeka (785) 291-8130, or visit our Web site at www.bcbsks.com
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/06

<table>
<thead>
<tr>
<th>ITEM</th>
<th>INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PROVIDER NAME (First Name, Middle Initial, Last Name)</td>
</tr>
<tr>
<td>2.</td>
<td>PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>PATIENT'S DATE OF BIRTH (MM DD YYYY)</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT'S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT'S CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>7.</td>
<td>INSURED'S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>8.</td>
<td>INSURED'S CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>9.</td>
<td>EMPLOYER'S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>10.</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
</tbody>
</table>

READ BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

14. DATE OF CURRENT ILLNESS (MM DD YYYY) |
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YYYY) |
16. DATES PATIENT WAS UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YYYY) TO (MM DD YYYY) |
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE |
18. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS FROM (MM DD YYYY) TO (MM DD YYYY) |
19. RESERVED FOR LOCAL USE |
20. OUTSIDE LAB? YES NO |
21. MEDICAID RESUBMISSION CODE |
22. PHYSICIAN OR SUPPLIER INFORMATION |
23. BILLING PROVIDER ID # |
24. DATE(S) OF SERVICE (MM DD YYYY) |
25. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) |
26. DIAGNOSIS POINTERS |
27. ACCEPT ASSIGNMENT? YES NO |
28. TOTAL CHARGE |
29. AMOUNT PAID |
30. BALANCE DUE |
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this DR and are made a part thereof.) |
32. SERVICE FACILITY LOCATION INFORMATION |
33. BILLING PROVIDER ID # |

SIGNED DATE

LEGEND:
- Helpful
- Not Required
- Required
- Required If Applicable
- Your Choice

This sample form is for Blue Cross and Blue Shield of Kansas educational purposes only and should not be used to submit actual claims. DO NOT DUPLICATE.
CANEY

AUTISM SPECIALISTS

MCVEY, TERESA L
2088 CR 2700
CANEY KS 67333-0000
(620) 289-4209

LAWRENCE

AUTISM SPECIALISTS

ZERR, KATIE L
2518 RIDGE CT #238
LAWRENCE KS 66046-0000
(785) 749-0121

SHAWNEE

AUTISM SPECIALISTS

KATZ, SHILOH R
12818 W 77TH ST
SHAWNEE KS 66216-0000
(913) 828-9533

TONGANOXIE

AUTISM SPECIALISTS

CLINE, MELISSA A
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

MADELEN, EILEEN
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

WHITE, RACHEL L
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

INTENSIVE INDIVIDUAL SUPPORT PROVIDERS

BENNIE, ASHLEY N
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

BOZARTH, SUSAN
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

GUNIA BARI, KRISTINA
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

MCKNIGHT, LAKRYSTAL
INTEGRATED BEHAVIORAL TECH INC
304 WEST ST
TONGANOXIE KS 66086-0000
(913) 417-7161

TOPEKA

AUTISM SPECIALISTS

BURGEN, LINDA M
THE CAPPER FOUNDATION
3500 SW 10TH AVE
TOPEKA KS 66604-0000
(785) 272-4060
State of Kansas

Contact Us

E-mail
Contact a customer service representative using our secure e-mail service when you have questions about your health insurance.

Telephone
For product information:
Contact your Human Resources Agency

Information for existing members:

**Blue Cross and Blue Shield of Kansas**
785-291-4185
1-800-332-0307

**Hearing impaired customers:**
1-800-430-1270

Mail
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

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