

## **Referrals and Prior Authorizations**

This section describes the referral and prior authorization processes and requirements for services provided to Humana – CareSource members. Please visit our provider portal at [CareSource.com/KY](http://CareSource.com/KY) for the most current information about prior authorization and referral requirements.

### Access to Utilization Management Staff

- Staff are available 8 a.m. to 5 p.m. Eastern time or inbound calls regarding utilization management (UM) issues
- Staff can receive inbound communication regarding UM issues after normal business hours
- Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
- Staff are available to accept collect calls regarding UM issues
- Staff are accessible to callers who have questions about the UM process

### Referrals

If you have questions about referrals and prior authorizations, please call medical management at 1-855-852-7005.

## **Medicaid Services That Do Not Require a Referral**

Some health care services provided by specialists do not require a referral from a PCP. Members may schedule self-referred services for participating providers. PCPs do not need to arrange or approve these services for members as long as applicable benefit limits have not been exhausted.

Services that do not require a referral include:

- Certified nurse midwife (CNM) services
- Certified nurse practitioner (CNP) services
- Chiropractic care (within benefit limits)
- Dental care (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services (e.g., Planned Parenthood)
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at community mental health centers only
- Psychological care (from private practitioners or at community mental health centers)
- Tuberculosis screening, evaluation and treatment
- Care at public health clinics
- Care at federally qualified health centers (FQHC) and rural health clinics (RHC)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours

- Services for children with medical handicaps

Medicaid members may go to nonparticipating providers for:

- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at FQHCs and RHCs

### **Medicaid Referral Procedures**

A referral is required for specialty services not listed above and for plan members to be evaluated or treated by most specialists. Treating doctors can refer Humana –CareSource members to specialists. Please refer to our website for more information on services that require a referral.

Simply put a note about the referral in the patient’s chart. Please remember, nonparticipating specialists must request prior authorization for services rendered to Humana – CareSource members. You can request a prior authorization by calling the Humana – CareSource medical management department at 1-855-852-7005 and select the option to request a prior authorization. You also can submit a request at [CareSource.com/KY](https://www.caresource.com/KY) select “Provider Portal” from the menu.

If you have difficulty finding a specialist for your Humana – CareSource member, please call provider services at 1-855-852-7005.

### **Steps to Make a Referral**

**Referring doctor** — Document the referral in the patient’s medical chart. You are not required to use a referral form or send a copy to our health plan. However, you must notify the specialist of your referral.

**Specialist** — Document in the patient’s chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records are subject to random audits to ensure compliance with this referral procedure.

**Standing Referrals** — A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

Members who meet the definition of Children with Special Health Care Needs (CSHCN) may access specialty care providers directly through the use of a standing referral. Members are instructed to obtain the standing referral from their PCP. CSHCNs are patients 6 months and older but younger than 21, who have asthma, HIV/AIDS, teen pregnancy, a letter of approval from the Bureau of Children with Medical Handicaps or are receiving Supplemental Security Income (SSI) for a chronic medical condition.

Referrals to out-of-plan providers — A member may be referred to out-of-plan providers if the member needs medical care that only can be received from a doctor or other health care provider who is not participating with our health plan. Treating providers must get prior authorization from Humana – CareSource before sending a member to an out-of-plan provider (see the “Prior Authorization” section).

Referrals for second opinions — A second opinion is not required for surgery or other medical services. However, health care providers or members may request a second opinion at no more cost to the member than if the service was obtained in network.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider. The provider must not be affiliated with the member’s PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

### **Prior Authorization Procedures**

Prior authorizations for health care services can be obtained by contacting the medical management department online, email, fax, phone or mail:

Visit the provider portal at the following web page:

<https://www.caresource.com/providers/kentucky/providerportal/>

Email: [KYMedicalManagement@caresource.com](mailto:KYMedicalManagement@caresource.com)

Fax: Please fax prior authorization forms to 1-888-246-7043.

Phone: Please call 1-855-852-7005 and follow the appropriate menu prompts for authorization requests, depending on your need.

Mail: Humana – CareSource  
Attn: Kentucky Medical Management  
P.O. Box 8738  
Dayton, OH 45401

When requesting an authorization, please provide the following information:

- Member/patient name and Humana – CareSource member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service

If the request is for inpatient admission for elective, urgent or emergency care, please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs.

If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When a prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. Humana – CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that a service is needed.

All services that require prior authorization from Humana – CareSource should be authorized before the service is delivered. Humana – CareSource is not able to pay claims for services in which prior authorization is required but not obtained by the provider. Humana – CareSource will notify you of prior authorization determinations by a letter mailed to the provider address on file.

For standard prior authorization decisions, Humana – CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than two business days following receipt of the request for service. Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

#### MEDICAID

Humana – CareSource partners with HealthHelp to provide consultation of Hi Tech Radiology Services. HealthHelp's RadConsult program provides expert peer consultation and the latest evidence-based medical criteria applicable to ensure the most appropriate high-tech imaging procedure or cardiac catheterization procedure. Ordering physicians should contact HealthHelp for the following outpatient, non-emergent procedures for consultation:

- MRI/MRAs
- CT/CTA scans
- PET scans

#### **Medicaid Services That Require Prior Authorization**

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to, the following services:

- All inpatient care
- All abortions
- Some home care services
- Nursing facility services

- Hospice care
- Organ transplants
- Cosmetic procedures and plastic surgery
- Orthodontia treatment and other dental services
- Ambulance transportation — except for emergent or facility-to-facility transfers
- Select durable medical equipment, regardless of amount, specifically:
  - All powered or customized wheelchairs
  - Manual wheelchair rentals longer than three months
  - All miscellaneous codes (example E1399)
  - Hearing aids
- Durable medical equipment (excluding the above items) and other supplies over \$750 billed charges
- Greater than 10 fetal non-stress tests per pregnancy
- Food supplemental/nutritional supplements (less than 30 cans per month)
- Pain management
- Services beyond benefit limits for members 20 years of age and younger

### **Surgical Procedure Forms**

Humana – CareSource accepts the same certification and consent forms for abortion, hysterectomy and sterilization procedures that the commonwealth accepts online at [CareSource.com/KY](http://CareSource.com/KY).

Prenatal Risk Assessment Forms (PRAFs) — Humana – CareSource is committed to helping providers manage the high-risk pregnancies of our members. We ask prenatal care providers to use prenatal risk assessment forms to communicate critical information to us about our pregnant members.

Please remember these guidelines when submitting prenatal risk assessment forms:

- Use a form designed for prenatal risk assessment documentation, such as the American College of Obstetrics and Gynecology (ACOG) form, the Hollister form or forms provided by Humana – CareSource. Please visit [CareSource.com/KY](http://CareSource.com/KY) for these forms. You may use your own office assessment form if you have one that captures the same information.
- We must receive the forms, filled out as completely as possible, no later than four weeks after the member's first prenatal visit.
- Please be sure to include the member's estimated delivery date (EDD) on the form.

- We accept copies or originals by fax or mail. Please fax forms to 1 -937-487-0260 or mail them to:

Humana – CareSource  
 Attn: Case Management  
 P.O. Box 221529  
 Louisville, KY 40252 -1529

We accept up to three assessment forms per pregnancy in case additional forms are needed for changes noted at subsequent visits.

Prenatal and postpartum care documentation — To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in member records:

- Evidence of prenatal teaching — This includes education on infant feeding, Women, Infant & Children (WIC), birth control, prenatal risk factors, dietary/nutrition information and childbirth procedures.
- Components of the postpartum checkup — This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

### **Utilization Management (UM)**

UM helps maintain the quality and appropriateness of health care services provided to Humana – CareSource members. The medical management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the Humana – CareSource case management team are made, if needed.

Humana – CareSource makes its UM criteria available by contacting us:

Fax: 1-888-246-7043  
Phone: 1-855-852-7005  
Email: [kymedicalmanagement@caresource.com](mailto:kymedicalmanagement@caresource.com)

On an annual basis, Humana – CareSource completes an assessment of satisfaction with the UM process and identifies areas for improvement opportunities.

Criteria — Humana – CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. This criteria is designed to assist health care providers in identifying the most efficient quality care practices in use today. It is not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. Humana – CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. Humana – CareSource also has medical policy statements developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a medical director for further review and determination.

Physician reviewers from Humana – CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request by contacting our medical management department at 1-855-852-7005.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. Humana – CareSource does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for the staff of Humana – CareSource that encourage decisions that result in underutilization.

Our members' health is always our No. 1 priority. Upon request, Humana – CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the Humana – CareSource medical management department. If you would like to discuss an adverse decision with a Humana – CareSource physician reviewer, please call the medical management department at 1-855-852-7005, ext. 5143, within five business days of the determination.

**Provider Appeals Procedure**

If you are dissatisfied with a determination made by our medical management department regarding a member's health care service or benefits, you may appeal the decision. Please see the "Appeal Procedures" section in this manual for information on how to file a clinical appeal.

**Retrospective Review**

A retrospective review is a request for a review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you have 180 days from the date of service or the inpatient discharge date or within 90 days from the primary insurance carrier's Explanation of Payment (EOP) to request a retrospective review for medical necessity.

Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service, 180 days from the inpatient discharge date or within 180 days of the date of the adverse decision letter. If you are appealing on the member's behalf with the member's written consent, you have up to 90 days from the date of service or the inpatient discharge date, or within 90 days of the date of the adverse decision letter. A request for retrospective review can be made by contacting the medical management department at 1-855-852-7005 and following the appropriate menu prompts, or by faxing the request to 1-888-527-0016. Clinical information supporting the service must accompany the request.