2014 Provider Manual

Kentucky Medicaid

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Welcome
Welcome and thank you for becoming a participating provider with Humana – CareSource®. We strive to work with our providers as partners to ensure that we make it as easy as possible to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.

We are a community-based health plan that serves Medicaid consumers throughout the commonwealth of Kentucky.

Our goal is to provide integrated care for our members. We focus on prevention and partnering with local health care providers to offer the services our members need to be healthy.

As a managed care organization (MCO), Humana – CareSource we improve the health of our members by utilizing a contracted network of high quality participating health care providers. Primary care providers (PCP) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

Humana – CareSource distributes the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:
- New members
- Existing members
- New providers
- Existing providers

About us
For the commonwealth of Kentucky's Medicaid MCO, Humana — the nation's premier health benefits innovator with its roots in Kentucky — has aligned with CareSource, an Ohio-based Medicaid health plan, to create a team that leverages deep Medicaid experience and capitalizes on proven expertise, strong resources and capabilities, established relationships and infrastructure. It combines the strengths of Humana's unmatched knowledge of service delivery in the Commonwealth with the Medicaid program expertise of CareSource, the second largest Medicaid managed care plan in the nation.

Our alliance is a strategic solution that merges the knowledge and experience of both companies to make the health care system work better for people eligible for both Medicare and Medicaid. Together, Humana and CareSource have the expertise, competencies and resources to make health care delivery simpler, while lowering costs and improving health outcomes. Our alliance allows members to receive the highest quality of care and services by offering:
- Care management and care transitions programs;
- Analytical tools to identify members who will benefit from special programs and services;
- An ongoing focus on customer service, health education and activities to promote health and wellness;
- Community engagement and collaboration to help ensure the comprehensive needs of members are addressed;
- Access to behavioral health services that includes a dedicated hotline and crisis intervention, and
- An award-winning history in member services, training, clinical programs and customer satisfaction, and

The ability to scale, innovate and provide ongoing support to our extensive health care provider network.

Humana – CareSource makes a difference
Humana – CareSource brings a history of innovative programs and collaborations to ensure that our members receive the highest quality of care. With a focus on preventive care and continued wellness, our approach is simple: we want to make it easier for our Members to get the health care they need, when they need it. Through community-based partnerships and services, we help our members successfully navigate complex health care systems.

Humana and CareSource have more than 50 years of managed care experience with the expertise and resources that come with it.

Our services include:
- Provider relations
- Member eligibility/enrollment information
- Claims processing
- Decision-support informatics
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud waste and abuse
- Member services, including a member call center and a 24-hour nurse advice line

In addition to the above, our care management programs include the following:
- Case management
- Onsite case management (clinics and facilities)
- Emergency department diversion
  - High emergency department utilization focus (targeted at members with frequent utilization)
  - 24-hour nurse advice line
- Maternal and healthy baby program

- Care transitions
  - Bridge to Home® (discharge planning and transitional care support)
- Disease management program for asthma and diabetes For more information on these programs, see the "Member Support Services and Benefits" section of this manual.

Removed Humana – CareSource Service Area (region 3 counties)

Compliance and Ethics
At Humana – CareSource, we serve a variety of audiences: members, health care providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana – CareSource policies and procedures.

Humana – CareSource is committed to conducting business in a legal and ethical environment. A compliance plan has been established by Humana and CareSource that:
- Formalizes Humana – CareSource's commitment to honest communication within the company and within the community, inclusive of our providers, members and employees.
- Develops and maintains a culture that promotes integrity and ethical behavior.
- Facilitates compliance with all applicable local, state and federal laws and regulations.
- Implements a system for early detection and noncompliance reporting with laws, regulations, fraud, waste and abuse concerns, or noncompliance with Humana – CareSource policy, professional, ethical or legal standards.
- Allows us to resolve problems promptly and minimize negative impact on our members or business including financial losses, civil damages, penalties and sanctions.

General Compliance and Ethics Expectations of Providers
- Act according to professional ethics and business standards.
- Notify us of suspected violations, misconduct or fraud, waste and abuse concerns.
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.
- Let us know if you have questions or need guidance for proper protocol.

For questions about provider expectations, please call your provider relations representative or call provider services at 1-855-852-7005.

We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

Personally Identifiable Information (PII)
In the day-to-day business of patient treatment, payment and health care operations, Humana – CareSource and its providers routinely handle large amounts of (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when it is stored, processed and transferred in the course of conducting normal business. As a health care provider, you should be taking measures to secure your patients' data. You also are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure all personal health information (PHI) related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents.
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII.

Accreditation
Humana – CareSource holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana and CareSource hold accreditation from the National Committee for Quality Assurance (NCQA) for their Medicaid lines of business.

Humana – CareSource's 24-hour nurse triage health call center also has been granted accreditation by URAC, a specific health call center accreditation that applies to organizations who provide triage and health information services over the telephone. These accreditation standards ensure that such services are performed in a manner that is timely, highly confidential and includes medically appropriate care and treatment advice.

Claims Submissions

Humana – CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all addresses and phone numbers on file with Humana – CareSource are up to date to ensure timely claims processing and payment delivery.

Billing Methods
Humana – CareSource accepts claims in a variety of formats, including paper and electronic claims.

We encourage providers to submit routine claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training and cost

Electronic Funds Transfer
Humana – CareSource now offers electronic funds transfer (EFT) as a payment option. Visit our provider portal at https://www.caresource.com/providers/kentucky/providerportal/ for additional information about the program and to enroll in EFT.

Providers who elect to receive EFT payment will receive an Electronic Remittance Advice (EDI) 835 file. Providers can download their Explanation of Payment (EOP) from the provider portal or receive a hard copy via the mail.

Benefits of EFT:
Simple — Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which increases payment processing efficiency.

Convenient — Available 24/7; works in conjunction with practice management systems. Humana – CareSource also offers free training for providers.

Reliable — Claim payments are electronically deposited into your bank account.

Secure — Access your account through the Humana – CareSource secure provider portal to view (and print, if needed) remittances and transaction details.

Simply complete the enrollment form at https://www.caresource.com/providers/kentucky/claims-information/ and fax it back to InstaMed, Humana – CareSource's EFT partner, at 1-877-755-3392. InstaMed will work directly with you to complete your enrollment in EFT.

Electronic Claims Submission
Electronic data interchange (EDI) is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). Our EDI system complies with HIPAA standards for electronic claims submission.

To submit claims electronically, providers must work with an electronic claims clearinghouse. Humana – CareSource currently accepts electronic claims from Kentucky providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

Please provide the clearinghouse with the Humana – CareSource payer ID number KYCS1.

Clearinghouse	Phone	Website
Emdeon	1-800-845-6592	www.emdeon.com
Quadax	1-866-422-8079	www.quadax.com
Relay Health	1-800-527-8133, Option 2	www.relayhealth.com
Practice Insight	1-713-333-6000	www.practiceinsight.net
Zirmed	1-877-494-7633	www.zirmed.com

File Format
Humana – CareSource accepts electronic claims in the 837 ANSI ASC X12N (004010A1) file format for professional and hospital claims.

Humana – CareSource 5010 companion guides are now available online. These companion guides provide Humana – CareSource trading partners with guidelines for submitting electronic transactions.

Version 5010 Companion Guides/HIPAA Transaction	Chapter Version
Humana – CareSource 837 Dental 5010 Companion Guide	Version 1.1
Humana – CareSource 837 Institutional 5010 Companion Guide	Version 1.1
Humana – CareSource 837 Professional 5010 Companion Guide	Version 1.1

Visit https://www.caresource.com/providers/ohio/ohio-providers/claims-information/5010-compliance/ for more information.

5010 Transactions
In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format.

Transactions covered under the 5010 requirement
- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 Prior authorization requests
- 834 Enrollment
- 820 Payment order/remittance advice
- NCPDP Version D

National Provider Identifier (NPI), Tax Identification Number (TIN or tax ID) and Taxonomy
Your NPI and tax ID are required on all claims, in addition to your provider taxonomy and specialty type codes (Federally Qualified Health Center, Rural Health Center and/or Primary Care Center) using the required claim type format (CMS-1500, UB92 or Dental ADA) for the services rendered. As of October 1, 2013, Kentucky Department for Medicaid Services (KDMS) requires that all NPIs, billing and rendering addresses and taxonomy codes are present on its Master Provider List (MPL). Claims submitted without these numbers, or information that is not consistent with the MPL, will be rejected. Please contact your EDI clearinghouse if you have questions on where to use the NPI, tax ID or taxonomy numbers on the electronic claim form you are submitting.

Location of Provider NPI, TIN and Member ID Number
On 5010 (837P) professional claims, the provider NPI should be in the following location:
- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification Code – NM109 = Rendering provider NPI
- For form CMS-1500, the rendering provider taxonomy code in box 24J. ZZ qualifier in box 24I for rendering provider taxonomy.
- For the ADA form, the billing provider taxonomy goes in box 52A and the rendering provider taxonomy goes in box 56A.

The billing provider tax identification number (TIN) must be submitted as the secondary provider identifier using a REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number (SSN) for individuals, see below:
- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN
- The billing provider taxonomy code in box 33b.

On 5010 (837I) institutional claims, the Billing Provider NPI should be in the following location:
- 2010AA Loop – Billing Provider Name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

The billing provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:
- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

- The Billing Taxonomy code goes in Box 81.

On all electronic claims, the Humana – CareSource member ID number should go on:
- 2010BA Loop = Subscriber Name
- NM109 = Member ID Number

Paper Claims
For the most efficient processing of your claims, Humana – CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process.

If you submit paper claims, please use one of the following claim form types:
- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 dental claim form
- CMS-1450 (UB-04), formerly UB92 form for facilities

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA). We cannot accept handwritten claims or super bills. Detailed instructions for completing each form type are available at the websites below.
- CMS-1500 Form Instructions
  http://www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: nucc.org

All claims (electronic and paper) must include the following information:
- Patient (member) name
- Patient address
- Insured's ID number — Be sure to provide the complete Humana – CareSource member ID for the patient.
- Patient's birth date — Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service — Use standard CMS location codes.
- ICD-9 diagnosis code(s) (or ICD-10 effective October. 1, 2015)
- HIPAA-compliant CPT or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable.
- Units, where applicable (anesthesia claims require number of minutes).
- Date of service — Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, when applicable — A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National provider identifier (NPI) — Please refer to sections for professional and Institutional claim information.
- Federal tax ID number or physician Social Security number — Every provider practice (e.g. legal business entity) has a different tax ID number.
- Billing and rendering taxonomy codes that match with the KDMS MPL
- Billing and rendering addresses that match with the KDMS MPL.
- Signature of physician or supplier — The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

Instructions for National Drug Code (NDC) on Paper Claims
All of the following information is required for each applicable code required on a claim:
- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code — F2, GR, ML or UN (only acceptable codes)

- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

What to Include on Claims that Require NDC

1. NDC and unit of measure (e.g., pill, milliliter [cc], international unit or gram)
2. Quantity administered – number of NDC units
3. NDC unit price – detail charge divided by quantity administered
4. HCPCS codes that will require NDCs on professional claims: (submitted on the 837P format)

Tips for Submitting Paper Claims

Humana – CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information to increase efficiency and to improve accuracy and turnaround time.

To Ensure Optimal Claims Processing Timelines

- EDI claims generally are processed more quickly than paper claims.
- If you submit paper claims we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with handwritten information) claims or super bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- Federal tax ID number or physician SSN is required for all claims submissions.
- All data must be updated and on file with the KDMS MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes.

Please mail or fax all Kentucky paper claim forms to Humana – CareSource at the following address:

Humana – CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824
Fax: 1-937-226-6916

Claim Submission Timely Filing

Claims must be submitted within 365 days of the date of service or discharge. We will not pay if there is incomplete, incorrect or unclear information on a claim. If this happens, providers have 365 days from the date of service or discharge to submit a corrected claim or file a claim appeal.

Claims Processing Guidelines

- Providers have 365 days from the date of service or discharge to submit a claim. If the claim is submitted after 365 days, the claim will be denied for timely filing.
- If a member has other insurance and Humana – CareSource is secondary, the provider may submit for secondary payment within 365 days of the original date of service.
- If a provider does not agree with the decision on a processed claim, he or she has 365 days from the date of service or discharge to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 days from the primary payer's EOB date. If a

copy of the claim and EOB are not submitted within the required timeframe, the claim will be denied for timely filing.
- All claims for newborns must be submitted using the newborn's Humana – CareSource ID number and the newborn's Kentucky Medicaid ID number. Do not submit newborn claims using the mother's identification numbers; the claim will be denied. Claims for newborns must include the birth weight.

Humana – CareSource established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services will be reimbursed at 65 percent of the Kentucky Medicaid fee schedule.

The following are exceptions to the January 1, 2014, reimbursement guidelines and will be reimbursed at 90 percent of the Kentucky Medicaid fee schedule:
- Emergency care (nonparticipating professional and facility services provided to members in an emergency room setting)
- Services provided for family planning
- Services for children in foster care

Searching for Claims Information Online
Claim status is updated daily on our provider portal and shows claims submitted in the previous 24 months. Searches by member ID number, member name and date of birth or claim number are available.

Additional Claims Enhancements on the Provider Portal:
- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claims payment date

Procedure and Diagnosis Codes
HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. Humana – CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on health care providers and health plan organizations. Local or proprietary codes are no longer allowed.
- International Classification of Diseases, 9th Edition, Clinical Modification
- (ICD-9-CM). Available from the U.S. Government Printing Office by calling 1-202-512-1800 or faxing 1-202-512-2250 and from other vendors
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml
- HCFA Common Procedure Coding system (HCPCS). Available at http://www.cms/hhs.gov/default.asp Procedures and Nomenclature. 2nd Edition (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org
- National Drug Codes (NDC). Available at http://www.fda.gov/

Procedures That Do Not Have a Corresponding CPT Code
If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
- A full, detailed description of the service provided.
- A report, such as an operative report or a plan of treatment.
- Other information that would assist in determining the service rendered.

For example, 84999 is an unlisted lab code that requires additional explanation.

Additional Coding/Claim Submission Guidelines
- Drug injections that do not have specific J code descriptions (J9999 and J3490) and an assigned HCPC J code that are not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.

- Abortion sterilization and hysterectomy procedure claims submissions must have consent forms attached. (Please see the "Supplemental/Form" section of this provider manual for these forms.)
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus other documentation that will assist in determining reimbursement.
- Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier.
- COB electronic claims require a copy of the primary carrier's payment information.

Code Editing
Humana – CareSource uses clinical editing software to evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

The clinical Humana – CareSource editing software finds coding conflicts or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Humana – CareSource software resolves these conflicts or indicates a need for additional information from the health care provider. Humana – CareSource clinical editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Humana – CareSource Provider Coding and Reimbursement Guidelines
Humana – CareSource strives to be consistent with KDMS, Medicare and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as hard copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, and ICD-9). Specific contract language stipulating the receipt, processing and payment of particular codes and modifiers are honored, as would be all aspects of a provider contract. When referenced in a contract, KDMS reimbursement rules (http://kymmis.com) are followed, depending on the state involved. In addition, the Center for Medicare & Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana – CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the following link for details: http://chfs.ky.gov/dms/fee.htm

Humana – CareSource uses coding industry standards, such as the AMA CPT manual, NCCI, and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:
- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Valid CPT/HCPCS code or modifier usage

Humana – CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, a claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration the previously mentioned commonwealth, Medicare, CCI and national commercial standards when considering an appeal. To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana – CareSource appeals team to consider why the code set(s) and modifier(s) being submitted differ from the standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current Humana – CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Explanation of Payment (EOP)
EOPs are statements of the current status of claims that have been submitted to Humana – CareSource and entered into our system. EOPs are generated weekly. However, providers may not receive an EOP weekly, each time they are generated depending on claim activity. Providers who receive EFT payments will receive an electronic remittance advice (ERA) and can access a "human readable" version on the provider portal.

Information Included on EOPs
EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online
Please remember that you can track the progress of submitted claims at any time through our provider portal.

Other Coverage — Coordination of Benefits (COB)
Humana – CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately and complying with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information that is updated periodically, and some updates may not always be fully reflected on our provider portal. Please ask Humana – CareSource members for all health care insurance information at the time of service.

Search COB on the provider portal by:
- Member number
- Case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with Humana – CareSource within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full ($0 balance) still must be submitted to Humana – CareSource for processing, due to regulatory requirements.

COB Overpayment
If a provider receives a payment from another carrier after receiving payment from Humana – CareSource for the same items or services, this is considered an overpayment. Humana – CareSource will provide 30 days written notice to the provider before any adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment will be made on a subsequent reimbursement. Providers also can issue refund checks to Humana – CareSource for overpayments and mail them to the address below. Providers should not refund money paid to a member by a third party.
Humana – CareSource
P.O. Box 824
Dayton, OH 45401-0824

Workers' Compensation
Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to Workers' Compensation for reimbursement.

Member Billing Policy
State and federal regulations prohibit health care providers from billing Humana – CareSource members for services provided to them except under limited circumstances. Humana – CareSource monitors this activity based on complaints of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices. Failure to comply with regulations after intervention may result in potential termination of your agreement with Humana – CareSource.

Regulations on Billing Members
Please remember that government regulations state that health care providers must hold members harmless in the event that Humana – CareSource does not pay for a covered service performed by the provider. The only exception is if Humana – CareSource denies prior authorization of the service, and you notify the member in writing that the member is financially responsible for the specific service. This notification must be done prior to providing the service and the member must sign and date the notification acknowledging his or her financial responsibility.

In compliance with federal and state requirements, Humana – CareSource members cannot be billed for missed appointments. Humana – CareSource encourages members to keep scheduled appointments and to call to cancel, if needed. Kentucky Medicaid may be able to offer transportation assistance to members for health care visits. For more information, please call 1-888-941-7433. Humana – CareSource provides emergency transportation as well as ambulance transportation to and from medical appointments when a member must be transported on a stretcher and cannot ride in a car. If you are concerned about a Humana – CareSource member who misses appointments, please call our case management department at 1-866-206-0272.

Providers should call provider services for guidance before billing members for services. You can reach provider services by calling 1-855-852-7005.

Communicating with Humana – CareSource
Humana – CareSource communicates with our provider network through a variety of channels, including phone, fax, provider portal, newsletters, website and network notifications.

Humana – CareSource Hours of Operation
Provider services:
Monday through Friday, 8 a.m. to 6 p.m. EST

Member services:
Monday through Friday, 7 a.m. to 7 p.m. EST
24-hour Nurse Advice Line 24/7/365

Please visit our website for the holiday schedule or contact provider services for more information.

Phone
To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option(s) that best fits your need. Please note that our menu options are subject to change. We also provide telephone based self-service applications that allow you to verify member eligibility.

Phone numbers

Provider relations	1-855-852-7005
Provider services	1-855-852-7005
Prior authorizations	1-855-852-7005
Case management	1-866-206-0272
Claims inquiries	1-855-852-7005
Credentialing	1-855-852-7005
Member services	1-855-852-7005
24-hour Nurse Advice Line	1-866-206-9599

Fraud, Waste and Abuse Hotline*	1-855-852-7005
TTY for the hearing impaired	1-800-648-6056 or 711

Fax numbers	
Case management referral	1-888-211-9858
Credentialing	1-502-508-0521
Fraud, Waste and Abuse*	1-800-418-0248
Medical prior authorizations	1-888-246-7043
Pharmacy prior authorizations	1-866-930-0019
Provider appeals	1-855-262-9793

Provider maintenance (e.g., office changes, adding/deleting providers) 1-800-626-1686

** Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.*

Website
Accessing our website CareSource.com/ky, is quick and easy. On the provider section of the site you will find commonly used forms, newsletters, updates and announcements, our provider manual, claims information, frequently asked questions and much more.

Provider Portal: ***https://providerportal.caresource.com/ky***
Our secure online provider portal allows you instant access at any time to valuable information, tools including clinical guidelines and other resources. Simply enter your User Name and Password (if already a registered user), or submit your information to become a registered user (see below). Assisting you is a top priority in order to achieve better health outcomes for our members.

Provider Portal Benefits
- A secure online (encrypted) tool that allows you to easily access time-saving services and critical information
- Available 24 hours a day, seven days a week
- Free
- Accessible on PCs without additional software

Provider Portal — Value to You
We encourage you to take advantage of the following time-saving tools:
- Payment History — Search for payments by check number or claim number
- Claims Information — Search for status of claims, claims recovery and claims appeals
- Coordination of Benefits (COB) — Confirm COB for members
- Explanation of Payment (EOP) — Access from the secure provider portal with the option to print
- Prior Authorization — Obtain authorizations for medical inpatient/outpatient, home health care and Synagis
- Eligibility Termination Dates — View a member's termination date (if applicable)
- Case Management Referrals — Submit case management referrals using the online referral form
- Dental and Vision History — View a member's dental and vision history, if applicable
- Provider Membership List — View provider membership rosters and implement changes and pharmaceutical services

Portal Registration
If you are not registered with the Humana – CareSource provider portal, please follow these easy steps:
1. Go to the provider portal, https://providerportal.caresource.com/KY/User/Login.aspx, and click on the "Register Now" button and complete the 3-step registration process. Note: You will need to have your tax ID number
2. Click the "Continue" button
3. Note the user name and password you create so that you can access the portal's many helpful tools
4. If you do not remember your user name/password, please call provider services at 1-800-852-7005

How to Communicate with Humana – CareSource by Mail

Correspondence address:
Humana – CareSource
P.O. Box 221529
Louisville, KY 40252-1529

Provider appeals mailing address:
Humana – CareSource
P.O. Box 823
Dayton, OH 45401-0823

Member appeals and grievances mailing address:
Humana – CareSource
P.O. Box 221529
Louisville, KY 40252-1529

Claims mailing address:
Humana – CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824

Fraud, waste and abuse mailing address:
Humana – CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

Please visit CareSource.com/KY for more information about submitting appeals online.

Newsletters
Humana – CareSource communicates with providers in a variety of ways. Our provider newsletter, produced three times a year, is available online and contains operational updates, clinical articles and new initiatives underway at Humana – CareSource. Please visit http://www.caresource.com/providers/kentucky/provider-materials/newsletters/ for the ProviderSource newsletter.

Network Notifications
Network notifications are published for Humana – CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our website, CareSource.com/ky, and the provider portal.

Provider Demographic Changes and Updates
Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Please submit changes promptly.

By mail:
Humana – CareSource
Attn: Provider Maintenance
12501 Lakefront Place
Louisville, KY 40299

Email: chcpr@humana.com

Fax: 1-800-626-1686

Covered Services and Exclusions

Covered Services

Please visit the Humana – CareSource website at CareSource.com/ky for information on common services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check that the member has not exhausted benefit limits before providing services by checking our website or calling provider services at 1-855-852-7005.

This section describes the services and exclusions to benefits that are provided to our Humana – CareSource members. Humana – CareSource covers all medically necessary covered services for members. These services are available to our health plan members at no charge. Covered services may require prior authorization. Please visit our website at caresource.com/KY for the most up-to-date list of services that require prior authorization. Under the "Provider section," click on "Member Care," and then "Prior Authorization."

Prior Authorization

Some services require prior authorization. Humana – CareSource reviews all service requests for Medicaid members under the age of 21 for medical necessity. If a request for authorization is submitted, Humana – CareSource will notify the provider and member in writing of the determination. If a service cannot be covered, providers and members have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Appeal Procedures" section of this manual for information on how to file an appeal.

Covered services and exclusions for Humana – CareSource members can be found at CareSource.com/KY. Click on "Provider," then "Member Care" then "Covered Services."

Covered Benefits and Services for Medicaid Members

Humana – CareSource covers abortions, hysterectomy and sterilizations in very limited circumstances. Please review the information below for specific information. Visit the "Forms" section of our website for all appropriate forms to complete for an abortion, hysterectomy or sterilization. For your convenience, Humana – CareSource also has tutorials to complete these forms on our website.

Abortion — Abortion Services are covered for eligible Humana – CareSource members in the following circumstances with prior authorization:

- Instances in which the woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- Instances in which the pregnancy was the result of an act of rape and the member, the member's legal guardian, or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the member was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.
- Instances in which the pregnancy was the result of an act of incest and the member, the member's legal guardian, or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code, unless the member was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.

Certification Form for Reimbursement of Abortion
The physician performing the abortion must certify in writing to one of these circumstances by completing the MAP 235 form. The physician performing the abortion must certify that one of the three circumstances above has occurred. The physician's signature must be in the physician's own handwriting. All certifications must contain the name and address of the member. The certification form must be attached to the claim. The form may be found on the Humana – CareSource website at CareSource.com/KY.

The certification must be as follows:
I certify that, on the basis of my professional judgment, this service was necessary because:

a. The woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
b. The pregnancy was the result of an act of rape and the member, the member's legal guardian or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency possessing the requisite jurisdiction.
c. The pregnancy was the result of an act of incest and the member, the member's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code.
d. The pregnancy was the result of an act of rape or incest, and in my professional opinion the member was physically unable to comply with the reporting requirement.

Reimbursement will not be made for associated services, such as anesthesia, laboratory tests or hospital services if the abortion service itself cannot be reimbursed.

Requirements for Sterilization
Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.
- Informed consent is obtained on the MAP 250 Consent to Sterilization Form which may be found on the Humana – CareSource website, aresource.com/ky, with legible signature(s) and submitted to our health plan with the claim.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.
- The procedure is scheduled at least 30 days, but not more than 180 days, after the consent is signed.

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

Requirements for a Hysterectomy
Written consent to the hysterectomy procedure must be obtained from members on the Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form MAP 251, which may be found on the Humana – CareSource website at www.caresource.com/ky. The primary surgeon performing the hysterectomy is responsible for securing the member's consent to the procedure.

A copy of the signed form must be provided for all hysterectomies, whether performed as a primary or secondary procedure, or for medical procedures directly related to such hysterectomies. The form should include legible signature(s) and be submitted to Humana – CareSource with the claim.

Abortion, Hysterectomy, Sterilization Forms and Instructions

All forms and instructions on how to complete the forms for an abortion, hysterectomy or sterilization are located in the forms section of our website at Caresource.com/KY.

Immunizations
Health care providers may administer immunizations obtained through the Vaccines for Children (VFC) program to Humana – CareSource members. The vaccines are available free of charge through the VFC program.

Members of the Kentucky Medicaid program who are 18 years of age or younger are eligible for the federally supported distribution of vaccines to improve immunization coverage levels for children. The Vaccines For Children (VFC) program is an agreement between the Department for Public Health and the Department of Medicaid Services to purchase and distribute vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC). The goal of the VFC program is to ensure that all children who meet the eligibility criteria receive the appropriate vaccines independent of his or her parent's ability to pay for the vaccine or its administration.

Who is Eligible to Receive VFC Vaccines?
Children, birth through 18 years of age (under 19 years of age) who:
- Are enrolled in Medicaid
- Do not have insurance
- Are American Indian or Alaskan Native
- Have health insurance that does not cover vaccines or are underinsured.

Underinsured children are eligible to receive VFC vaccines only at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

How do I enroll in the VFC program as a provider?
To enroll, providers may contact his or her 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. Participating providers who administer vaccines must enroll in the VFC program through the CHFS. Participating providers must use the VFC vaccines for Humana – CareSource members.

Contact Information
For questions regarding vaccines or immunizations, contact the Kentucky Immunization program at 1-502-564-4478.

Humana – CareSource pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code.

Please see the "Member Support Services and Benefits" section for more details on immunizations. Humana – CareSource will not reimburse costs for vaccines obtained outside the VFC program when provided to children younger than 19.

Annual Wellness Exams for Adults
All adults are eligible to receive a wellness exam from a PCP at the earliest opportunity upon enrollment with Humana – CareSource. A wellness exam may be performed annually and consists of the following:
- Routine physical exam, including (but not limited to) urinalysis, Pap smear, hemoccult, general health screen panel and other lab tests as indicated.
- Screening which consists of the following, as appropriate:
  - Mammography performed at intervals recommended by the American Cancer Society and American College of Obstetrics and Gynecology for age and risk factors
  - Prostatic-specific antigen for males
  - Flexible sigmoidoscopy every three years beginning at age 40
  - Colonoscopy as indicated for patients with high risk factors
  - Flu shots, as appropriate
  - Vision exams through PCP or vision vendor

– Hearing exams

Please visit our provider portal at https://providerportal.caresource.com/KY for up-to-date clinical and preventive care guidelines.

Behavioral Health
Behavioral health and substance use services are covered services for Humana – CareSource members. Humana – CareSource is contracted with Beacon Behavioral Health for the provision of these services. Providers, members or other responsible parties should contact the behavioral health department at 1-855-852-7005 to verify available behavioral health and substance use benefits, and to seek an appointment or direction for obtaining behavioral health and substance use services.

Humana – CareSource members have access to specialty behavioral health case managers for assistance in obtaining both routine and higher complexity health care services through our contracted vendor, Beacon. Humana – CareSource PCPs also can contact Beacon for assistance in facilitating specialty behavioral health services for our members. Beacon provides a comprehensive range of behavioral health care services for Humana – CareSource members. Services include outpatient routine office visits for therapy and medication management, a broad range of hospital-based services for both behavioral health and substance dependence disorders, home-based therapy services and access to community-based resources. Beacon will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatric services.

Humana – CareSource coordinates between behavioral health service providers and PCPs. Humana – CareSource requires that behavioral health service providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

Humana – CareSource requires that behavioral health providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent.

Credentialing and Re-credentialing
Humana – CareSource credentials and re-credentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action.

Through credentialing, Humana – CareSource checks the qualifications and performance of physicians and other health care practitioners. Our senior clinical staff person is responsible for the credentialing and re-credentialing program.

You may submit a completed Council for Affordable Quality Healthcare (CAQH) Application via:

Humana – CareSource
Attention: Credentialing
12501 Lakefront Place
Louisville, KY 40299
Fax: 1-502-508-0521

CAQH Application
Humana – CareSource is a participating organization with CAQH. Please make sure that we have access to your provider application by:

1. Logging onto the CAQH website at CAQH.org utilizing your account information
2. Selecting the Authorization Tab
3. Making sure Humana – CareSource is listed as an authorized health plan
4. If not, please check the Authorized box to add

It is essential that all documents are complete and current. Please include copies of the following documents:
- Malpractice Insurance Fact Sheet
- A current Drug Enforcement Administration (DEA) Certificate
- Clinical Laboratory Improvement Amendment (CLIA) Certificate (if applicable)
- Collaborative Practice Agreement if an advanced registered nurse practitioner)

Humana – CareSource conducts credentialing and re-credentialing activities utilizing the guidelines from the Kentucky Department of Medicaid Services (KDMS), the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

Contracted providers listed in the provider directory and the following are credentialed:
- Practitioners who have an independent relationship with Humana – CareSource. This independent relationship is defined through contracting agreements between Humana – CareSource and a practitioner or group of practitioners and is defined when Humana – CareSource selects and directs its enrollees to a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners who are hospital-based, but see Humana - CareSource members as a result of their independent relationship.
- Dentists who provide care under Humana – CareSource medical benefits.
- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.

The following providers do not need to be credentialed:
- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the Humana – CareSource provider directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

Provider Selection Criteria
Humana – CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

Quality of care delivery, as defined by the Institute of Medicine, states:
"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Humana – CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. Humana – CareSource bases selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner. The following selection criteria have been put in place and are assessed during the credentialing and re-credentialing process, in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:
a. Active and unrestricted license in the state issued by the appropriate licensing board
b. Previous five-year work history
c. Current Drug Enforcement Administration (DEA) certificate (if applicable)
d. Successful completion of all required education
e. Successful completion of all training programs pertinent to one's practice

f. For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
g. For dentists and other providers where special training is required or expected for services being requested, successful completion of training
h. Board certification, if applicable
i. Education, training and experience are current and appropriate to the scope of practice requested
j. Malpractice insurance at specified limits established for all practitioners by the credentialing policy
k. Good standing with Medicaid and Medicare
l. Medicaid number
m. Quality of care and practice history as judged by:
    i. Medical malpractice history
    ii. Hospital medical staff performance
    iii. Licensure or specialty board actions or other disciplinary actions, medical or civil
    iv. Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
    v. Other quality of care measurements/activities
    vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
    vii. Lack of issues on Health & Human Services-Office of Inspector General (HHS-OIG); General Services Administration (GSA, formerly EPLS)
n. Signed, accurate credentialing application and contractual documents
o. Compliance with standards of care and evidence of active initiatives to engage members in preventive care
p. Agreement to comply with plan formulary requirements or acceptance of plan preferred drug list as administered through pharmacy benefit manager
q. Agreement to access and availability standards established by the health plan
r. Compliance with service requirements outlined in the provider agreement and provider manual

Organizational Credentialing and Re-credentialing
The following organizational providers are credentialed and re-credentialed:
- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free standing ambulatory surgery centers

Additional organizational providers also are credentialed:
- Hospice Providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- Freestanding Birth Centers

The following elements are assessed for organizational providers:
1. Provider is in good standing with state and federal regulatory bodies.
2. Provider has been reviewed and approved by an accrediting body.
3. Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
4. Liability insurance coverage is maintained.
5. Copy of facility's state license (if applicable).
6. CLIA certificates are current.
7. Completion of a signed and dated application.

Providers will be informed of the credentialing committee's decision within 60 business days of the committee meeting. Providers will be considered re-credentialed unless otherwise notified.

Practitioner Rights

- Practitioners have the right to review, upon request, information submitted to support his or her credentialing application to the Humana – CareSource Credentialing Department. Humana – CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing Department prior to presentation to the credentialing committee. If any information obtained during the credentialing or re-credentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or re-credentialing application upon written request to the credentialing department.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana – CareSource will initiate immediate action in the event that the participation criteria no longer are met. Providers are required to inform Humana – CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

Re-credentialing

Providers are re-credentialed a minimum of every three years. As part of the re-credentialing process, Humana – CareSource considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG and GSA (formerly EPLS). Providers will be considered re-credentialed unless otherwise notified.

Board Certification Requirements

All physicians applying to become participating providers with Humana – CareSource must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board.

Delegation of Credentialing/Re-credentialing

Humana – CareSource will only enter into agreements to delegate credentialing and re-credentialing if the entity that wants to be delegated is NCQA accredited for these functions, utilizes a NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and re-credentialing policies and procedures
- Credentialing and re-credentialing committee meeting minutes from the previous year
- Credentialing and re-credentialing file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity, which will be defined in an agreement between both parties.

Appeals of Credentialing/Re-credentialing Decisions

Humana – CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from Humana – CareSource's network. If this

happens, the applying or participating provider will be notified in writing. Appeal opportunities are available to a participating provider if he or she has been affected by an adverse determination. To submit an appeal request, the following steps apply:

Step 1 — Submit to the senior medical director an appeal request in writing, along with any other supporting documentation. Send it to:

Humana – CareSource
Attn: Dr. Sylvester Barczak, Senior Medical Director
640 Eden Park Drive
Cincinnati, OH 45202

Step 2 — If the committee maintains its original decision, an appeal may be made consistent with provisions of the Humana – CareSource Fair Hearing Plan. An appeal request must be submitted in writing and received by Humana – CareSource within 30 days of the date the provider is notified of the first appeal decision. Appeals may be sent to:

Humana – CareSource
Attn: Dr. Sylvester Barczak, Senior Medical Director
640 Eden Park Drive
Cincinnati, OH 45202

Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.

Provider Disputes
Provider disputes related to quality, professional competency or conduct should be sent to:

Humana – CareSource
Attn: Dr. George Andrews, Quality Improvement
500 W. Main St.
Louisville, KY 40202

Provider disputes that are contractual or nonclinical should be sent to:

Humana – CareSource
Attn: Dr. George Andrews, Provider Relations
101 S. Fifth St.
Louisville, KY 40201

Adverse Actions
Humana – CareSource complies with the federal Health Care Quality Improvement Act and has an active peer review committee. Humana – CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider, who, in the opinion of the Humana – CareSource senior medical director or peer review committee, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Participating providers who are subject to an adverse action that affects their status for more than 30 days are offered an opportunity for a fair hearing that entails an additional physician panel review of the action.

Cultural Considerations and Competencies
Participating providers are expected to deliver services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

Humana – CareSource recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the health care experience and health outcomes. It is committed to developing strategies that eliminate health disparities among culturally diverse groups and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in health care. Unequal treatment found racial differences in the type of care delivered across a wide range of health care settings and disease conditions, even when controlling for socioeconomic status factors, such as income and insurance coverage. Annual National Healthcare Disparities Reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American health care system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health-care-seeking behaviors. Providers can address racial and ethnic gaps in health care with awareness of cultural needs and by improving communication with their growing number of diverse patients.

Humana – CareSource offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Initiatives from other health-related organizations give providers other resources and materials that emphasize and support awareness of gaps in care and information on culturally competent care.

In addition, Humana – CareSource recognizes cultural differences in religious beliefs and ethical principles. As a result, providers are not required to perform a treatment or procedure that is contrary to their religious beliefs or ethical principles.

Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and Humana – CareSource. As a result, we have a comprehensive fraud, waste and abuse program in our special investigations unit. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms

Fraud is defined as “An intentional deception or misrepresentation made by a recipient or provider with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

Waste involves taxpayers not receiving reasonable value for money in connection with government-funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Abuse is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to the Medical Assistance Program, or that result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.” Abuse also results when recipient practices result in unnecessary costs to the Medical Assistance Program or the obtaining of goods, equipment, medicines or services that are not medically necessary or that are excessive, or constitute flagrant overuse or misuse of Medical Assistance Program benefits for which the recipient is covered.

Knowingly means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

Improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. It also includes payment to an ineligible recipient, payment for an ineligible good or

service, duplicate payment, payment for a good or service not received (except for such payments where authorized by law) and payment that does not account for credit for applicable discounts. (Improper Payments Elimination and Recovery Act [IPERA]).

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e. changing prescription forms to get more than the amount of medication prescribed by his or her physician
- Sharing prescription ID cards
- Not disclosing other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information to providers in order to get treatment, drugs, etc.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower reimbursement rates
- Billing for tests or services not provided
- Intentionally using improper medical coding to receive a higher reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking Member ID's resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they were outpatients
- Accepting payments from kickbacks or Stark violations
- Retaining overpayments made in error by Humana – CareSource
- Preventing Members from accessing eligible or covered services

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Dispensing prescription drugs inconsistent with the order
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted or illegal drugs
- Billing for prescriptions not filled or picked up

Examples of Employee Fraud, Waste and/or Abuse:

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business data or reports
- Not reporting or taking action on employee's are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

The Humana – CareSource special investigations unit routinely monitors for potential fraud, waste and abuse. .When found, an investigation is initiated and, if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal action

The provider agreement outlines specific information on each type of provider termination/suspension. The fair hearing plan provides information on an appeal process and is available online by searching for “Fair Hearing Plan” at CareSource.com/KY

Anyone who identifies questionable activity related to fraud, waste or improper payments is encouraged to report it to Humana – CareSource using one of the reporting methods outlined at the end of this section.

The Federal and State False Claims Acts and other Fraud, Waste and Abuse Laws
Using the False Claims Act, you can help reduce fraud against the federal government. The act allows everyday people to bring “whistleblower” lawsuits on behalf of the government — known as “qui tam” suits — against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

As amended in 2009, the False Claims Act addresses those who:

a. Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval
b. Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim
c. Conspires to commit a violation of any other section of the False Claims Act
d. Has possession, custody or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property.
e. Is authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property
g. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government

A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act. See below.

Other Fraud, Waste and Abuse Laws (section not new, just moved up from a later part in the section)

- Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value including a kickback, bribe or rebate, in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.
- Under the Federal Stark Law, and subject to certain exceptions, physicians are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. 18 U.S.C. §1347.

There are significant penalties for violating the False Claims Act. Civil penalties include fines for each false claim and may be tripled. In addition to civil penalties, courts also can impose criminal penalties.

Kentucky Law

Kentucky has not enacted a false claims statute with a qui tam provision comparable to the federal False Claims Act. However, Kentucky law does permit the Kentucky attorney general to prosecute any individual or entity that:

- knowingly or wantonly devises a scheme or plans a scheme or artifice, or enters into an agreement, combination or conspiracy to obtain or aid another in obtaining payments from medical assistance programs by means of any fictitious, false or fraudulent application, claim, report or document submitted to the Cabinet for Health and Family Services or intentionally engages in conduct which advances the scheme or artifice;
- intentionally, knowingly or wantonly makes, presents, or causes to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious or fraudulent statement, representation, or entry in any application, claim, report or document used in determining rights to any benefit or payment;
- intends to defraud, knowingly makes, or induces, or seeks to induce the making of a false statement or false representation of a material fact with respect to the conditions or operations of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled-nursing facility, intermediate-care facility, home-health agency or other provider of services to the Medical Assistance Program; or
- knowingly falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

The complete set of Kentucky laws governing Medicaid fraud and abuse may be found at Kentucky Revised Statutes §§205.8451-205.8483.

Protection for Reporters of Fraud, Waste or Abuse

Federal and state law and Humana – CareSource's policy prohibit retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Special Investigations Unit using one of the reporting methods outlined at the end of this section.

Incentives for Whistleblowers

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement.
(Section not deleted, just moved to earlier in the section)
Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on our website at www.caresource.com/ky.

Prohibited Affiliations/ 42 C.F.R. § 438.610

Humana – CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and no procurement activities. Relationships must be terminated with trustees, officers, employees, providers or vendors who are identified to be debarred, suspended or otherwise excluded from participation in federal or state health care programs. If you become aware that you or your office management staff have a prohibited affiliation, you must notify us immediately using the contact information in the reporting section below.

Confidentiality
Physicians shall prepare, maintain and retain as confidential the health records of all members receiving health care services, and members' other personally identifiable health information received from Humana – CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions
Before Humana – CareSource enters into or renews an agreement with your practice or corporate entity; you must disclose debarment or suspension status and criminal convictions related to federal health care programs. This disclosure includes you, your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately, including a change in ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by using the contact information in the reporting section below.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste or Abuse
It is Humana – CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our special investigations unit. Reporting fraud, waste or abuse can be anonymous.
Options for reporting anonymously:

- Call: 1-855-852-7005 and follow the appropriate menu option for reporting fraud
- Write: Humana – CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- Fax: 1-800-418-0248
- Email*: fraud@caresource.com

You also may choose to use the Fraud, Waste and Abuse Reporting Form located at www.caresource.com/ky.

** Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, to help protect your privacy, please use the form or phone number to report your concerns.*

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.

A Roadmap to Avoid Medicare and Medicaid Fraud and Abuse

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud,

waste and abuse. This brochure can be found on the Office of Inspector General's website at: http://oig.hhs.gov/compliance/physician-education/ index.asp.

To report fraud, waste and abuse directly to OIG, you can call 1-800-372-2970. Hours are Monday through Friday, 8 a.m. to 4:30 p.m. Eastern Time. You also can leave a secure voicemail message and an investigator will return you call.

Thank you for helping Humana – CareSource keep fraud, waste and abuse out of health care.

Quality Performance Measures

Humana – CareSource Quality care for our members is the cornerstone of Humana – CareSource's foundation and a hallmark of our commitment to make a difference. Humana – CareSource uses the Healthcare Effectiveness Data and Information Set (HEDIS®) as one measure of the quality of care delivered to Humana – CareSource members. NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90 percent of the nation's health plans. HEDIS scores are compiled using claims and medical records.
Humana – CareSource also utilizes performance measures that have been developed in collaboration with the commonwealth and the External Quality Review Organization (EQRO), based on key areas of interest for the population we serve. These measures align with the Healthy Kentuckians 2020 Leading Health Indicators. The full complement of measures address access to, timeliness of, and quality of care provided to children, adolescents, and adults enrolled in managed care organizations and focuses on preventive care, health screenings, prenatal care, as well as special populations (adults with hypertension and children with special health care needs [CSHCN]).

The following HEDIS measures are key focus areas for Humana – CareSource and can help providers identify care opportunities for their patients. These specific measures can be found on ncqa.org or http://chfs.ky.gov/dph/hk2010MidDecade.htm

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Measure Overview:

Adult Body Mass Index (BMI)
The percentage of individuals 18-74 years of age who had an outpatient visit and whose body mass index was documented in the medical record

Controlling High Blood Pressure
Individuals 18-85 years of age with a diagnosis of hypertension should have their blood pressure documented in the medical record and their blood pressure is controlled (for HEDIS reporting this measure is defined as <140/90)
Cholesterol Management (removed)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- The percentage of members 3-17 years of age who had evidence of the following during the measurement year:
  - BMI percentile documentation
  - Counseling for nutrition
  - Counseling for physical activity

Annual Dental Visit
The percentage of members 2-21 years of age who had at least one dental visit during the measurement year.

Lead Screening
The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Well-Child Visits in the First 15 Months of Life
The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. The well-child visit must have the following components:

- Health education/anticipatory guidance
- Physical exam
- Health and developmental history (physical and mental)

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The well-child visit must have the following components:

- Health education/anticipatory guidance
- Physical exam
- Health and developmental history (physical and mental)

Adolescent Well-Care Visits
The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The well-care visit must have the following components:

- Health education/anticipatory guidance
- Physical exam
- Health and developmental history (physical and mental)

Children and Adolescents' Access to Primary Care Practitioners
The percentage of members 12 months-19 years of age who had a visit with a PCP

Adults' Access to Preventive/Ambulatory Health Services
The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

Prenatal and Postpartum Care
The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November. 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Timeliness of Prenatal Care – The percentage of deliveries that received a prenatal care visit as a member of Humana – CareSource in the first trimester or within 42 days of enrollment in the organization; and
- Postpartum Care – The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Kentucky State Specific Measures

- Cholesterol screening
- Prenatal and postpartum risk assessment counseling and education
- Adolescent screening/counseling
- Individuals with special health care needs (ISHCN) access and preventive care
- Weight assessment and counseling for children and adolescents
- Weight assessment/BMI assessment and counseling for adults

Key Contract Provisions

To make it easier for you, we have outlined key components of your contract with Humana – CareSource. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Participating providers are responsible for:

- Providing Humana – CareSource with advance written notice of intent to terminate an agreement with us. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead.
- Sixty-day notice is required if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting Humana – CareSource members for a 60-day period following notification.
- For PCPs only: Providing 24-hour availability to your Humana – CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.
- Submission of claims and corrected claims should take place within 365 days of the date of service or discharge.
- Filing appeals within 365 days of the date of service or discharge.
- Keeping all demographic and practice information up to date.

Our agreement also indicates that Humana – CareSource is responsible for:

- Paying 90 percent of clean claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a Humana – CareSource determination regarding claims payment. Our appeal process is outlined in the "Provider Appeals" section of this manual.
- Offering a 24-hour nurse triage service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance up to our allowable rate for covered services. If the member's primary insurance pays a provider equal to or more than the Humana – CareSource fee schedule for a covered service, Humana – CareSource will not pay any additional amount. If the member's primary insurance pays less than the Humana – CareSource fee schedule for a covered service, Humana – CareSource will reimburse the difference up to the Humana – CareSource allowable rate.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow industry standard-practice procedures even though they may not be spelled out in our provider agreement.

Physician Responsibilities:

- Participating providers are expected to make daily visits to their patients who have been admitted as inpatients to an acute care facility or arrange for a colleague to visit.
- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating providers are expected to treat members with respect.

Humana – CareSource members should not be treated differently than patients with other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual.

Humana – CareSource expects participating providers to verify member eligibility and ask for all his or her health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage we have on file by logging onto www.caresource.com/ky and selecting "Provider Portal" from the menu options.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing.

Timeline of Provider Changes:

Type of Change	Minimum Notice Required
New providers or providers leaving	

the practice, ownership changes or convictions	Immediate
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Provider's intent to terminate	90 days

Why is it Important to Give Changes to Humana – CareSource?
This information is critical to process your claims. In addition, it ensures our provider directories are up to date and reduces unnecessary calls to your practice. This information also is reportable to Medicaid and Medicare.

Member Enrollment and Eligibility

Member Enrollment
Medicaid eligibility is determined by the Department for Community Based Services (DCBS) in the county where the consumer resides.

The commonwealth provides eligibility information to Humana – CareSource on a daily basis via an 834 file for members assigned to Humana – CareSource. Eligibility begins on the first day of each calendar month for consumers joining Humana – CareSource, with two exceptions:

1. Newborns, born to an eligible mother, will be eligible upon birth; and
2. Consumers who meet the definition of unemployed in accordance with 45 CFR 233.100 will be eligible on the date they are deemed unemployed.

Medicaid Member ID Cards

All new Humana – CareSource members receive a Humana – CareSource membership ID card in addition to the state Medicaid ID card. New Humana – CareSource ID cards are not issued monthly as are state Medicaid ID cards. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

The member ID card is used to identify a Humana – CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana – CareSource and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to every service.

Providers may use the secure provider portal on our website to check member eligibility or call provider services.

Provider portal: https://providerportal.caresource.com/KY
Click on "Member Eligibility" on the left, which is the first tab.

Provider Services: 1-855-852-7005
Members are asked to present an ID card each time services are accessed.

If you are not familiar with the person seeking care, and cannot verify the person as a member of our health plan, please ask to see photo identification.

Information included on the Humana – CareSource ID card:

Member's Name

Humana – CareSource Member's ID # *use this number on claims.*

MMIS *# is the Member's State Medicaid ID number; please do* ***not*** *use this to bill Humana – CareSource.*

Member Services *phone number and TTY for the hearing impaired.*

Nurse Advice Line

Member's Date of Birth *this number may be valid for multiple household members. It is not the member's ID number.*

Primary Care Provider/Clinic Phone Number *Members choose a participating provider to be his/her primary care provider (PCP). If a choice is not made, a PCP is assigned.*

(Back of member ID card)

Behavioral Health Hotline Number

Website — *Our Website contains plan information as well as special functionality: verify eligibility, check claims and prior authorization status, submit a prior authorization, check COB and more.*

Provider Services
The toll-free phone number for providers who have questions or wish to verify eligibility over the phone.

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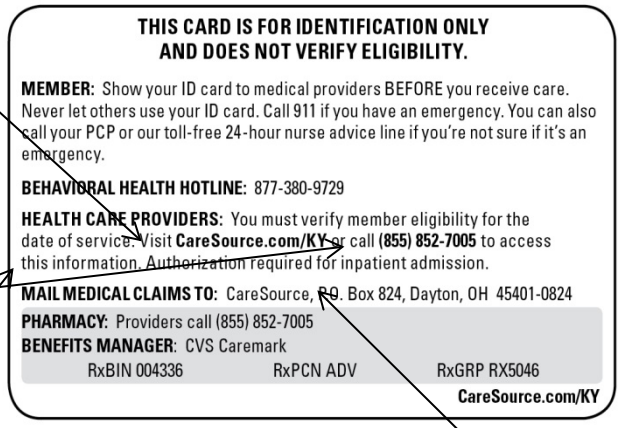
Send Paper Claims
Humana – CareSource
P.O. Box 824
Dayton, OH 45402-0824



Pharmacy Information

Please note: Humana – CareSource may be notified by the commonwealth that a member has lost eligibility retroactively. This occurs occasionally, and in those situations, Humana – CareSource will take back payments made for dates when a member lost eligibility. The take-back code will appear on the next Explanation of Payment (EOP) for impacted claims.

Medicaid Member Eligibility Verification:
Before providing all services EXCEPT emergency services, providers are expected to verify member eligibility.

- Log on to www.caresource.com/ky and select "Provider Portal" from the menu options. Using our secure provider portal, you can check Humana – CareSource member eligibility up to 24 months after the date of service. You can search by date of service plus any one of the following: member name and date of birth, case number, Medicaid (MMIS) number or Humana – CareSource member ID number. You can submit multiple member ID numbers in a single request.
- Call our automated member eligibility verification system at 1-855-852-7005 and follow the appropriate menu options to reach our automated member eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the member ID number and the month of service to check eligibility.

Each month, primary care providers (PCP) can view a list of eligible members who have chosen them or are assigned to them as of the first day of that month. Log onto our secure provider portal to view or print your membership list.

Eligibility changes can occur throughout the month, and the member list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility on date of service.

Newborn Enrollment
Humana – CareSource begins coverage of newborns on his/her date of birth when the newborn's mother is a member of a Humana – CareSource Medicaid plan. The newborn will appear on the PCP's member eligibility list after it is added to the Humana – CareSource system.

To verify eligibility for a newborn, please use the secure provider section of our website at www.caresource.com/ky and select "Provider Portal" from the menu options. Once you enter the mother's case number, you should be able to view all eligible members of the household.

Member Disenrollment
Members may disenroll from Humana – CareSource for a number of reasons. If members lose Medicaid eligibility, they lose eligibility for Humana – CareSource benefits. Humana – CareSource, DCBS or the member can initiate disenrollment.

Reasons for Member Disenrollment
- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify the Humana – CareSource care management department if one or all of the situations listed above occur. Review the "Member Support Services and Benefits" section for more information. Please see the section below for procedures for dismissing noncompliant members from your practice. We can counsel the member, or in severe cases, initiate a request to DCBS for disenrollment. DCBS will review each of our requests for member disenrollment and determine if the request should be granted. Disenrollment from Humana – CareSource will always occur at the end of the effective month.

Procedures for Dismissing Non-compliant Members
Participating health care providers can request that a Humana – CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include: noncompliance with medication schedules, no-show office policies or failure to modify behavior as requested. When a member misses three or more consecutive appointments, providers are asked to notify our care management department for assistance.

Humana – CareSource requires that a provider's office make at least three attempts to educate the member about noncompliant behavior and document them in the patient's record. Please remember that Humana – CareSource's outreach staff can assist you in

educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below.

- The provider office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent or faxed to Humana – CareSource at the following address:

  Mail: Humana – CareSource
  Attn: Member Services Manager
  P.O. Box 221529
  Louisville, KY 40252-1529
  Fax: 1-937-226-6916

For PCPs only: The letter must contain specific language stating that:

- The member must contact Humana – CareSource member services to choose another PCP.
- The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Please call provider services at 1-855-852-7005 if you have questions about disenrollment reasons or procedures.

Automatic Renewal of Membership

If Humana – CareSource members lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in Humana – CareSource and assigned to the same PCP, if possible.

Member Support Services and Benefits

Humana – CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

Medicaid New Member Identification Cards and Kits

Each new member household receives a new member kit, a welcome letter and an ID card for each person in the family who has joined Humana – CareSource. New member kits are mailed separately from the ID card and new member welcome letter.

Medicaid new member kit contains:

- Information on how to obtain a copy of the Humana – CareSource provider directory
- A member handbook which explains plan services and benefits and how to access them
- A health assessment survey
- Humana – CareSource ’s Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information

Member Services
Humana – CareSource provides assistance to members who have questions or concerns about services or benefits. Members can contact our member services department by calling 1-855-852-7005 (TTY for the hearing impaired: 1-800-648-6056). Representatives are available by telephone Monday through Friday, 7 a.m. to 7 p.m. Eastern Time, except on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after, Christmas Eve and Christmas Day. If the holiday falls on a Saturday, the company will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

24-Hour Nurse Advice Line: 1-866-206-9599
Members can call our nurse advice line 24 hours a day, seven days a week, except on the specified holidays given above. Members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support. Nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of the PCP role in coordinating the member's care.

Key features of this service include qualified nurses who:
- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members access our 24-hour nurse advice line anytime night or day. The phone number is on the member's ID card.

Care Management/Outreach
Humana – CareSource provides integrated care management services through medical and behavioral health nurses, social workers and outreach specialists who provide one-on-one personal interaction with members. We also have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging noncompliant members, reinforcing medical instructions and assessing social needs, as well as educating pregnant women and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many diseases.

“Direct Access” for case management referrals and assistance with member needs is available 24 hours a day, seven days a week. Call for Direct Access: 1-866-206-9599. Please feel free to refer members who might need individual attention to help them manage special health care challenges.

Care Management Services

Humana – CareSource’s care management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. We promote a holistic approach through the integration of physical and behavioral health to assist the member across a continuum of care. More importantly, it’s designed to support and enhance the care and treatment you provide to your patient. We stress the importance of establishing the medical home, early and ongoing identification of barriers, and keeping appointments. We assist in arranging transportation to the provider’s office if necessary. This one-on-one personal interaction between the patient and with other health care professionals provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote increased independence and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources.

Humana – CareSource encourages you to take an active role in your patient’s care management program and we invite and encourage you to direct and participate in the development of a comprehensive care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for our members.

We offer individualized education and support for many conditions and needs, including:

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs

Care Management for High-Risk Members

Humana – CareSource provides a comprehensive integrated care management model for our highest-risk members. Utilizing nurses and social workers, this multi-disciplinary approach integrates Case Management Society of America (CMSA) standards of practice to help members overcome health care access barriers. It also strengthens our provider and community resource partnerships through collaboration. The multidisciplinary care management teams are led by RNs who perform a comprehensive assessment of the member’s clinical status, develop an individualized treatment plan with individualized goals, monitor outcomes and evaluate the outcomes for possible updates to the care plan.

Typical high-risk members may have multiple medical issues, socioeconomic challenges and behavioral health care needs.

Humana – CareSource Disease Management Program
Humana – CareSource Medicaid members with chronic conditions, including asthma and diabetes, are automatically enrolled into Humana – CareSource's disease management program. Members enrolled in the program will receive educational information to help them better manage their asthma or diabetes. Information sent to members includes care options for them to discuss with his or her provider. Members identified as high risk have a nurse assigned to their case to help educate, coordinate and provide resources and tools to help the member optimize their overall health.

How to Refer Members to Disease Management
If you have a Humana – CareSource patient with asthma or diabetes who you believe would benefit from this program and is not already enrolled, please call 1-866-206-0272.

Emergency Department Diversion Program
Humana – CareSource is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. Members are advised to call 911 or go to the nearest emergency room (ER) if they feel they have an emergency. Humana – CareSource covers all emergency services for our members.

We instruct members to call their PCP or our 24-hour nurse advice line if they are unsure if they need to go to an ER. Humana – CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our Care Management for analysis or intervention. It is our goal at Humana – CareSource to reduce inappropriate and/or avoidable ER use among our members through education, identification and removal of barriers, and by linking the members to a regular source of care. Humana – CareSource takes a proactive approach by assisting its members with accessing the most appropriate health care resources before an emergency arises. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Perinatal Care Management
Humana – CareSource has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with members and providers. We encourage our prenatal care providers to notify our care management department at 1-866-206-0272 when a member with a high-risk pregnancy has been identified.

Babies First Program
Pregnant members and new mothers can earn up to $150 in gift cards to local stores by receiving recommended prenatal care for themselves and preventive well child-care for their children through age 15 months. Members can obtain Babies First brochures and coupons from Humana – CareSource. Each coupon contains reminders about keeping all scheduled prenatal appointments and other helpful information relevant to a given

trimester. Once the activities on the coupon have been completed, members mail the coupons to Humana – CareSource for verification in order to receive gift cards. If you provide prenatal or preventive services, Humana – CareSource members may ask you to validate coupons by completing information on the back of the coupon and providing a signature

Eyeglass Frames
Members of our health plan can choose from a large selection of eyeglass frames, in addition to those approved by Medicaid, at no cost to them. These frames must be ordered through one of Humana – CareSource's contracted optical labs. Please refer to www.caresource.com/ky for additional information about vision services.

Interpreter Services — Nonhospital Providers
Humana – CareSource offers sign and language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We also provide select printed materials in other languages or formats, such as large print and we are available to explain the materials as needed. These services are available at no cost to the member or health care provider. As a provider, you are required to identify the need for interpreter services for your Humana – CareSource patients and offer appropriate assistance. To arrange services, please contact provider services at 1-855-852-7005 (TTY: 1-800-648-6056 or 711). Please inform us of any members in need of interpreter services, as well as members that receive interpreter services through another resource.

Interpreter Services — Hospital Providers
Humana – CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can provide select printed materials in other languages or formats, such as large print, and we are available to explain the materials as needed. Hospital providers are required to identify the need for interpreter services for Humana – CareSource patients and offer appropriate assistance. If you do not have access to interpreter services, contact provider services at 1-855-852-7005 (TTY: 1-800-648-6056 or 711). Please inform us of members in need of interpreter services, as well as members who receive interpreter services through another resource.

EPSDT Program
Early Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program developed for children through the age of 20 who are Medicaid recipients. All children younger than 21 who are Humana – CareSource members should receive EPSDT exams. The program is designed to provide comprehensive preventive health care services at regular intervals. EPSDT stresses health education to children and their caretakers in the areas of early intervention and treatment of problems discovered during exams, and ongoing health maintenance.

EPSDT Exam Components
The EPSDT exam is a general health assessment composed of the following required screening elements:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Developmental assessment and mental health screening
- Vision and eye assessment
- Nutritional assessment
- Dental assessment and referral to a dentist, as indicated. Dental referrals are recommended at 1 to 3 years of age; they are required at 3 years and older
- Assessment of immunization status and administration of required vaccines
- Anemia test using hematocrit or hemoglobin determinations, if indicated
- Health education
- Sickle cell test, if indicated
- Complete urinalysis, if indicated
- Test for sexually transmitted diseases, if indicated
- Tuberculin test, if indicated
- Lead screening test at indicated times
- Pelvic examination, if indicated

EPSDT Exam Frequency
The recommended schedule for EPSDT exams is as follows:

- Birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Annually after age 2 through age 20

PCPs receive a list at the beginning of each month that contains eligible Humana – CareSource members who have chosen or been assigned to them as of that date. The list includes indicators for patients who are due for an EPSDT exam. If there is a “Y” in the Exam Due column, that member is due to receive an EPSDT exam in the following month. You can find this list on our website at www.caresource.com/ky.

EPSDT Form
Please document all required components of the EPSDT exam in the member’s medical record. We encourage you to use the EPSDT form to ensure that you capture all of the needed data. The EPSDT Form can be found on www.caresource.com/ky.

EPSDT Codes
Exams should be coded on claim forms using CPT codes 99381 through 99395, whichever is applicable, as indicated in the following chart. Correct codes are required for proper documentation of services provided and timely and accurate claims payment.

New Patient/Initial Exam

CPT Code	Description
99381	Infant (age under 1 year)
99382	Early childhood (age 1-4 years)
99383	Late childhood (age 5-11 years)
99384	Adolescent (age 12-17 years)
99385	Age 18-20 years

Established Patient/Periodic Exam

CPT Code	Description
99391	Infant (age younger than 1 year)
99392	Early childhood (age 1-4 years)
99393	Late childhood (age 5-11 years)
99394	Adolescent (age 12-17 years)
99395	Age 18-20 years

These codes should be used along with appropriate ICD-9 diagnosis codes (V20.2 or V70.x codes). When updating routine EPSDT status at the time of an acute care visit, use E&M CPT code (99201 – 99204 or 99212 – 99214) along with the appropriate ICD-9 code to indicate the reason for the acute care visit as a secondary diagnosis.

EPSDT Exam Referrals

If the PCP is unable to provide all of the components of the EPSDT exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within Humana – CareSource's provider network in accordance with Humana – CareSource 's referral procedures. The member's medical record must indicate to where the member was referred.

Blood Lead Level Testing

The Kentucky Medicaid program requires that children receive a blood lead level test at 1 and 2 years of age. This is a required part of the EPSDT exam provided at these ages. Filter paper testing is an accepted method for obtaining blood lead levels and is approved by the commonwealth.

The filter paper method offers fast, quantitative results from two drops of blood obtained through a finger stick capillary puncture. Both hemoglobin and lead can be tested using this method and CPT code 36416 for the capillary stick. It is a less invasive method of sample collection that can be performed conveniently in a physician's office. Supplies and instructions are provided by the labs that process the results. Supplies are provided at no charge and lab results are delivered within 48 hours of receipt. Lead levels that

exceed 10 ug/dL with this sampling method are recommended for retesting by a follow-up capillary or venous puncture according to guidelines. For more information, please contact a participating lab. Participating labs and their contact information can be found by using our “Find a Doctor/Provider” tool.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care Providers to administer to children under the age of 19 who are eligible for Medicaid. To become a VFC Provider, contact your Cabinet for Health and Family Services (CHFS) immunization program field staff representative for your location. A contact list of field staff representatives can be found at www.chfs.ky.gov/dph/epi/Health+Care+Professionals.htm. Participating providers who administer vaccines to Humana – CareSource members must enroll in the VFC program through CHFS and must use the VFC vaccines for members. Vaccines are provided to program participants at no cost. Providers will be reimbursed to administer vaccines to members under the age of 19.

Humana – CareSource will not reimburse costs for vaccines obtained outside the VFC when provided to children under age 19.

Please bill Humana – CareSource with the appropriate CPT and ICD-9 vaccination codes for the immunization(s) administered and the appropriate administration code. Humana – CareSource will pay for the administration of the vaccine only. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during EPSDT exams as needed. Humana – CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current schedule can be found at the website www.aap.org.

Immunization Codes (chart is not new)

Immunization	**CPT codes**	**ICD-9-CM codes**
DtaP	90698, 90700, 90701, 90720, 90721, 90723	99.39
Diphtheria and Tetanus	90702	
Diphtheria	90719	V02.4*, 032*, 99.36
Tetanus	90703	037*, 99.38
Pertussis		033*, 99.37
IPV	90698, 90713, 90723	V12.02*, 045*, 99.41
MMR	90707, 90710	99.48

Measles	90705, 90708	055*, 99.45
Mumps	90704	072*, 99.46
Rubella	90706, 90708, 90709	056*, 99.47
HiB	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748	041.5*, 038.41*, 320.0*, 482.2*
Hepatitis B**	90723, 90740, 90743, 90744, 90746, 90747, 90748	V02.61*, 070.2*, 070.3*
VZV	90710, 90716	052*, 053*
Pneumococcal Conjugate	90669, 90670	

Please bill Humana – CareSource with the following CPT vaccination codes, along with the appropriate ICD-9 vaccination codes, to receive reimbursement for administration of these vaccines.

* *Indicates evidence of disease. A member who has evidence of disease during the numerator event time is compliant for the antigen.*

** *The two-dose hepatitis-B antigen Recombivax is only recommended for children between 11 and 14 years of age.*

Americans with Disabilities Act
The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects.

The following are commonly asked questions and answers, with more detailed information available at www.cdihp.org:

Q. Which health care providers are covered under the ADA?
A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health care providers covered by the Title III of the ADA. Title III applies to all private health care providers regardless of size. It applies to providers of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA. Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA. Health care providers that offer training sessions, health education or conferences to the public must make these events accessible to individuals with disabilities.

Q. What kinds of modifications to policies or procedures might be required?
A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time

to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room. The ADA does not require providers to make changes that would fundamentally alter the nature of their service.

Q. How does a health care provider determine which auxiliary aid or service is best for a patient?
A. The health care provider can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?
A. No. A health care provider cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

Q. In what medical situations should a health care provider obtain a sign language interpreter?
A. If a patient or responsible family member usually communicates in sign language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures, and providing complex instructions regarding medication). If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

Q. When must private medical facilities eliminate from existing facilities architectural and communication barriers that are structural in nature?
A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual provider.

Q. How does one remove "communication barriers that are structural in nature?"
A. For instance, the installation of permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems and raised character and Braille elevator controls would characterize structural communication barriers.

Q. What if a patient thinks that a health care provider is not in compliance with the ADA?
A. If a health care provider cannot satisfactorily work out a patient’s concerns; various means of dispute resolution including arbitration, mediation or negotiation are available. Patients also have the right to file an independent lawsuit in federal court, and to file a formal complaint with the U.S. Department of Justice.

Excerpted from and based on, “ADA Q and As” by Deborah Leuchovius, ADA Specialist, Parent Advocacy Coalition for Educational Rights (PACER) 8161 Normandale Blvd., Bloomington, MN 5543.

Health Education
Humana – CareSource members receive health information from Humana – CareSource through a variety of communication vehicles including easy-to-read newsletters, brochures, phone calls and personal interaction. Humana – CareSource also sends preventive care reminder messages to members via mail and automated outreach messaging.

Member Rights and Responsibilities
As a Humana – CareSource provider you are required to respect the rights of our members. Humana – CareSource members are informed of their rights and responsibilities via their member handbook. The list of our member's rights and responsibilities is below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Members have the right:

a. To receive all services that Humana – CareSource must provide and receive them in a timely manner without communication or physical access barriers.
b. To choose a provider who gives you care whenever possible and appropriate.
c. To choose a primary care provider (PCP) and to change your PCP to another PCP in Humana – CareSource's panel. When you make a PCP change, Humana – CareSource will send you written confirmation of your new PCP.
d. To obtain a second opinion from a qualified provider on Humana – CareSource's panel. If a qualified provider is not able to see you, Humana – CareSource must set up a visit with a provider not on our panel.
e. To timely referral and access to medically indicated specialty care.
f. To be given information about your health. This information may also be available to someone you have legally approved to have the information or who you have indicated should be reached in an emergency when it is not in the best interest of your health to give it to you.
g. To ask questions and receive complete information relating to your medical condition and treatment options in a way that you can understand. This includes information regarding specialty care.
h. To discuss information on appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
i. To take part in decisions about your health care unless it is not in your best interest.
j. To say no to treatment or therapy. If you say no, the doctor or managed care plan (MCP) must talk to you about what could happen and they must put a note in your medical record about it.
k. To be treated with respect, dignity, privacy, confidentiality and nondiscrimination.
l. To consent to or refuse treatment or active participation in decision choices.
m. To be sure others cannot hear or see you when you are receiving medical care.
n. To be free from forms of restraint or seclusion used as a means of force, coercion, discipline, convenience, ease, retaliation or revenge as specified in federal regulations.
o. To receive assistance with medical records in accordance with applicable federal and state laws.
p. To be sure that your medical record information is kept private.

q. To ask for and receive one free copy of your medical records and be able to ask that the record be changed/corrected, if needed. Additional copies shall be made available to members at cost.

r. To be able to say yes or no to having any information about you given out, unless Humana – CareSource has to provide it by law.

s. To be able to get all Humana – CareSource written member information from us:
   i. at no cost to you;
   ii. in the prevalent non-English languages of members in the Humana – CareSource service area;
   iii. in other ways, to help with the special needs of members who may have trouble reading the information.

t. To be able to get help free of charge from Humana – CareSource and our providers if you do not speak English or need help in understanding information.

u. To be able to get help with sign language if you are hearing impaired.

v. To be told if the health care provider is a student and to be able to refuse his/her care.

w. To be told of any experimental care and to be able to refuse to be part of the care.

x. To know that Humana – CareSource must follow all federal and state laws, and other laws about privacy that apply.

y. If you are a female, to be able to go to a woman's health provider on Humana – CareSource's panel for covered woman's health services.

z. To receive access to the grievance process and have a channel to voice grievances about Humana – CareSource or the care you receive and obtain assistance in filing an appeal, and request a state fair hearing from the Humana – CareSource and/or the Department of Medicaid Services.

aa. To prepare advance medical directives including living wills or durable powers of attorney for health care.

bb. To contact the U.S. Department of Health and Human Services Office of Civil Rights and/or the Bureau of Civil Rights at the following address with complaints of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:

Office of Civil Rights
United States Department of Health and Human Services
Sam Nunn Atlanta Federal Center
61 Forsyth St. S.W.
Suite 16T70
Atlanta, GA 30303-8909
1-800-368-1019
Fax: 1-404-562-7881
TDD: 1-800-537-7697

cc. To receive information about Humana – CareSource, our services, our practitioners and providers and member rights and responsibilities.

dd. To make recommendations regarding Humana – CareSource's member rights and responsibility policy.

ee. To be free to carry out your rights and know that Humana – CareSource or our providers will not hold this against you.

Humana – CareSource may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.

Members of Humana – CareSource also are informed of the following responsibilities:

a. To become informed about member rights.
b. To abide by Humana – CareSource and the Department's policies and procedures.
c. To become informed about service and treatment options.
d. To actively participate in personal health and care decisions and practice healthy lifestyles.
e. To understand as much as possible about your health issues and take part in reaching goals that you and your health care provider agree upon.
f. To report suspected fraud and abuse.
g. To use only approved providers.
h. To keep scheduled doctor appointments and be on time. If you have to cancel, call 24 hours in advance.
i. To follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
j. To always carry your ID card and present it when receiving services.
k. To never let anyone else use your Humana – CareSource ID card.
l. To notify Humana – CareSource and the Department of Community Based Services of a change in your phone number or address.
m. To contact your PCP after going to an urgent care center or after receiving medical care outside of Humana – CareSource's covered counties or service area.
n. To let Humana – CareSource and the Department of Community Based Services know if you have other health insurance coverage.
o. To provide the information that Humana – CareSource and your health care providers need in order to provide care for you.

Member Privacy

Members are notified of Humana – CareSource 's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Humana – CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the Humana – CareSource organization.

The notice also informs members about how they may obtain a statement of disclosures or request their medical claim information. Humana – CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI), of members. As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Pharmacy

Members who are eligible for a Medicaid managed care plan (MCP) may elect coverage with Humana – CareSource. This coverage includes retail prescription drugs, many of which are administered in the patient's home.

Medicaid providers who prescribe for Humana – CareSource members must contact the MCP for medication prior authorizations.

Details of MCPs Administering Prescription Drug Coverage:

- Copayment requirements — Members are not required to pay a co-payment for prescription drugs. Some medical supplies are now covered under the MCO plan, including diabetes supplies, spacers, peak flow meters and condoms.
- Other medical supplies and durable medical equipment (DME) — To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, can be filled by the Humana – CareSource pharmacy benefit manager for a limited time, until a DME provider can be contracted.
- Medications administered in the provider setting — Medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the MCO. Prior authorization requirements now exist for many injectables.
- Transition period —There is a 30 day transition period for MCP members transferring from one MCP to another. After the 30-day transition period has ended, prior authorization may be applicable depending on the member's medications. To avoid disruption to a member's medication(s) it is extremely important to quickly identify which drugs require prior authorization. Please check the website for what medications require prior authorization or call 1-855-852-7005 before the next refill.

A "quick list" of preferred drugs is available at CareSource.com/KY.

Network Pharmacy

Our pharmacy directory gives you a complete list of our network pharmacies and all of the pharmacies that have agreed to fill covered prescriptions for Humana – CareSource plan members. Please visit our website for a complete list of network pharmacies at CareSource.com/KY.

For questions pertaining to pharmacy prior authorization requests, please contact us at 1-855-852-7005 or fax 1-866-930-0019.

Tell us the Medical Reasons for Exceptions

Typically, our preferred drug list includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we generally will not approve a request for an exception.

You must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information when you ask for the exception.

Approval/Denial of Drug Exceptions
If we approve your request for an exception, the approval period will be communicated to you. The approval period is valid as long as you continue to prescribe the drug for your patient and that drug continues to be safe and effective for treating the condition.

If we deny your request for an exception, you can ask for a review of our decision by making an appeal. Please review the "Appeals" section of this manual for details on how to submit appeals.

Appeals
An appeal is a request to change a previous decision made by Humana – CareSource as defined as a special kind of complaint. A member may file an appeal if he/she disagrees with a health care services decision, prescription drugs or payment for services and/or prescription drugs. Members also may file an appeal if he or she disagrees with a decision to stop services he or she is receiving. For example, a member may ask for an appeal if our plan doesn't pay for a particular drug, item or service he or she wants to receive.

Our members' health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first.

Please contact us for grievances, organization determinations, coverage determinations and appeals questions. We will work with you to try to find a satisfactory solution.

Primary Care Providers (PCP)
All Humana – CareSource members choose or are assigned to a PCP upon enrollment in the plan. PCPs help facilitate a "medical home" for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

Members select a PCP from our health plan's provider directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling member services. PCP changes are effective on the first day of the month following the requested change.

Provider Education
Humana – CareSource will conduct an initial educational orientation for all newly contracted providers within 30 days of becoming active. Providers receive periodic and/or targeted education as needed.

PCP Roles and Responsibilities
Primary care providers shall:
1. Be responsible for supervising, coordinating and providing initial and primary care to members;
2. Be responsible for initiating referrals for specialty care;

3. Be responsible for maintaining the continuity of patient care 24 hours per day, seven days a week;
4. Have hospital admitting privileges or a formal referral agreement with a primary care provider who has hospital admitting privileges.

In addition, Humana – CareSource PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member;
- Continuity of the member's total health care;
- Early detection and preventive health care services;
- Elimination of inappropriate and duplicate services.

PCP care coordination responsibilities include at a minimum, the following:

- Treating Humana – CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Maintaining continuity of the member's health care.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Making referrals for specialty care and other medically necessary services, both in- and out-of-network if such services are not available within the Humana – CareSource network.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana – CareSource and the Commonwealth of Kentucky as outlined in this manual.
- Discussing advance medical directives with all members as appropriate.
- Providing 30 days of emergency coverage to any Humana – CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds the Department of Medicaid Services' specifications.
- Obtaining patient records from facilities visited by Humana – CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Referring members to behavioral health providers and arranging appointments, when clinically appropriate.
- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care, including ESPDT for persons under the age of 21.
- Recommending referrals to specialists, as required.
- Participating in the development of case management care treatment plans and notifying Humana – CareSource of members who may benefit from case management.

Kentucky Lock-In Program (KLIP)
KLIP is a program designed for individuals enrolled in Medicaid in Kentucky who need help managing their health care needs. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the enrollee. Humana – CareSource members who meet the program criteria will be locked in to:

- One primary care physician (PCP)
- One controlled substance prescriber, if needed
- One pharmacy

KLIP is required by the Kentucky Department for Medicaid Services.

Humana – CareSource monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. If a review of a member's claim activity reveals an unusually large number of claims for medically unnecessary treatment, services or medications, the member is considered a candidate for KLIP.

Members identified to be enrolled in KLIP receive written notification from Humana – CareSource, along with the designated lock-in provider's information and the member's right to appeal the plan's decision.

Members are initially locked-in for a total of 24 months, during which the member can only request a change from their designated lock-in provider one time.

Following the member's 24 month enrollment, utilization review for KLIP members is conducted at 12-month intervals to determine the member's continued need for the program.

Primary care providers with KLIP members shall do the following:

- Provide services and manage the KLIP member's necessary health care needs
- Complete and forward the Lock-in Recipient Referral Form (hyperlink to form) to a referred provider, including any provider covering for the PCP, when the lock-in member needs a Medicaid-covered service other than the services of the designated primary care provider
- Participate in the member's periodic utilization review to determine continued lock-in status
- Serve as the lock-in member's designated controlled substance prescriber, if the designated primary care provider is a physician

Referred providers offering services to KLIP members shall:

- Receive and sign the Lock-In Recipient Referral Form, completed by the PCP and delivered by the member
- Submit the signed Lock-In Recipient Referral Form with the claim

Referral to Lock-in Program:
Humana – CareSource will monitor member claims history and utilization to identify members who may benefit from enrollment in the Lock-in Program. Members may also be referred for evaluation for participation in the Lock-in Program by their primary care physician or a specialist who is caring for the member. Excluded from enrollment in the lock-in program are members who:

- reside in a facility reimbursed pursuant to 907 KAR 1:025 or 1:065 or in a personal care home
- are under the age of 18
- receive services through a home- and community-based waiver program or hospice services
- utilized Medicaid services at a frequency that was medically necessary to treat a complex, life-threatening medical condition

For further information or questions about the Kentucky Lock-in Program, please contact Humana – CareSource provider services at 1-855-852-7005.

Advanced Directives

PCPs have the responsibility to discuss advance medical directives with adult members who are 18 years of age or older and who are of sound mind at the first medical appointment and subsequently chart that discussion in the permanent medical record of the member. A copy of the advance directive should be included in the member's medical record inclusive of any mental health directives.

The PCP should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

Medical Records

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved in order to ensure quality of care. The medical chart organization and documentation shall, at a minimum, require the following:

a. Member/patient identification information, on each page;
b. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information;
c. Date of data entry and date of encounter;
d. Provider identification by name;
e. Allergies, adverse reactions and known allergies shall be noted in a prominent location;
f. Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chickenpox);
g. Identification of current problems;

h. The consultation, laboratory and radiology reports filled in the medical record shall contain the ordering provider's initials or other documentation indicating review;
i. Documentation of immunizations pursuant to 902 KAR 2:060;
j. Identification and history of nicotine, alcohol use or substance abuse;
k. Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
l. Follow-up visits provided and (secondary) reports of emergency room care;
m. Hospital discharge summaries;
n. Advanced Medical Directives, for adults;
o. All written denials of service and the reason for the denial; and
p. Record legibility to at least a peer of the writer. Records judged illegible by one reviewer shall be evaluated by another reviewer.

A member's medical record shall include the following minimal detail for individual clinical encounters:
a. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status;
b. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) addressed from previous visits;
c. Plan of treatment including:
    1. medication history, medications prescribed, including the strength, amount, directions for use and refills;
    2. therapies and other prescribed regimen; and
    3. follow-up plans including consultation and referrals and directions, including time to return.

Prenatal and Postpartum Care Documentation
To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:
- Evidence of prenatal teaching — This includes education on infant feeding, 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.

Well Child Care/EPSDT Program
The Well-Child/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a child-health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All Humana – CareSource members under age 21 must receive well-child/EPSDT exams. The program supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources. For the complete listing of the American Academy of Pediatrics (AAP) Preventive Health Guidelines visit www.aap.org.

High-Risk Children
Children at high risk should be tested according to AAP guidelines. Problems found or suspected during a well-child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and the AAP's recommendations for preventive pediatric health care or presenting need.

Blood Lead Level Testing
The Kentucky Medicaid program requires that all children have at least one blood lead level test by the age of 2. Filter paper testing is an accepted method to obtain blood lead levels and is covered by Humana – CareSource.

Immunization Schedule
Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana – CareSource endorses the same recommended childhood immunization schedule that is recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates can be found on the AAP website at www.aap.org.

Provider Appeals Procedures

Provider Appeals and Grievance Procedures
You have the right to file a grievance or an appeal with Humana – CareSource regarding a provider payment issue or a contractual issue.

If you do not agree with a decision of a processed claim, you have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required timeframe the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

Humana – CareSource shall resolve a provider grievance or appeal within 30 calendar days. Humana – CareSource may request a 14 day extension from you to resolve your grievance or appeal.

Please note: If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal. Providers have 365 days from the date of service or discharge to submit a corrected claim.

Humana – CareSource ensures that no punitive or retaliatory action is taken against a member or service provider who files a grievance or appeal or a provider who supports a member's grievance or appeal.

How to Submit a Provider Grievance or Appeal
Claims Appeals: Providers can submit grievances and claims appeals through our secure provider portal, or in writing:

Provider Portal: https://providerportal.caresource.com/ky

After logging in to the provider portal, click on the “Claims Appeals” tab on the left.

For grievances or appeals submitted in writing, please include:
- The member’s name and Humana – CareSource member ID number
- The provider’s name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination

Mail: Humana – CareSource
Attn: Provider Appeals
P.O. Box 823
Dayton, OH 45401

Fax: 1-855-262-9793

Member Grievance, Appeals and Fair Hearing Requests
Members have the right to file a grievance or appeal. They also have the right to request a state hearing once they have exhausted their appeal rights. As a Humana – CareSource provider, we may contact you to obtain documentation when a member has filed a grievance or appeal or has requested a state hearing. State and federal agencies require Humana – CareSource to comply with all requirements, including aggressive resolution timeframes.

Members are encouraged to call or write to Humana – CareSource to let us know of complaints regarding Humana – CareSource or the health care services they receive. Members or legal guardians may file a grievance or appeal with Humana – CareSource. Authorized representatives and providers, with the member’s written consent, also may file a grievance or appeal with Humana – CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members, legal guardians and providers can contact Humana – CareSource at 1-855-852-7005 (TTY: 1-800-648-6056 or 711) to learn more about these procedures.

Member Grievances — When members inform us that they are dissatisfied with Humana – CareSource or one of our providers, it is a grievance. A member has 30 calendar days from the date of an event causing dissatisfaction to file a grievance with Humana – CareSource, either orally or in writing. Humana – CareSource investigates all grievances. Humana – CareSource has five working days of receipt of the grievance to notify the member that the grievance has been received and when resolution of the grievance is expected. An investigation and final resolution of a grievance shall be completed within 30 days of the date the grievance is received by Humana – CareSource.

Member Appeals
Members have the right to appeal an adverse action or decision made by Humana – CareSource. An adverse action for the purpose of an appeal is:
- The denial or limited authorization of a requested service, including the type or 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;
- The failure of the Humana – CareSource to provide services in a timely manner, as defined by the department or its designee;
- The failure of the Humana – CareSource to complete the authorization request in a timely manner as defined in 42 CFR 438.408; or
- The denial of a member's request to exercise his or her right, under § 438.52(b) (2) (ii), to obtain services outside the network when the member resides in a rural area with only one MCO.

Members have the right to appeal the decisions or actions listed above if they contact Humana – CareSource within 30 calendar days of receiving the notice of adverse action. Any timely oral appeal must be followed by a written appeal signed by the enrollee within 10 calendar days. Within five working days of receipt of an appeal, Humana – CareSource shall provide the member with written notice that the appeal has been received and the expected date of its resolution.

Humana – CareSource will respond to the appeal within 30 calendar days of when it was received unless the member or Humana – CareSource requests an extension and it can be demonstrated that additional time is needed. An extension shall be no longer than 14 days. Expedited appeals are resolved within 72 hours of the receipt of the request.

An appeal will be expedited when it is determined the resolution time for a standard appeal could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.
Punitive or retaliatory actions will not be taken against:
- A member or provider who files a grievance or an appeal
- A provider who supports a member's grievance or appeal

State Fair Hearings
Once members have exhausted their appeal rights they can request a state fair hearing if Humana – CareSource makes a decision to deny, reduce, suspend or stop care for a member. Members have 30 days from receiving Humana – CareSource's final decision to request a state fair hearing.

If Humana – CareSource proposes to reduce, suspend or terminate a service already approved, members may request continuation of benefits until a state fair hearing is held; however, the member may be liable for the cost.

Members may request a state fair hearing through the Department for Medicaid Services. They can submit their request in writing, by fax or in person to:

Kentucky Department for Medicaid Services
Division of Administration and Financial Management
275 E. Main St., 6W-C
Frankfort, KY 40621
Fax number: 1-502-564-6917

Members can call the Kentucky Department for Medicaid Services with questions at 1-800-635-2570.

How to Submit a Grievance or Appeal
Grievances and claims appeals can be submitted through our secure provider portal, by fax or by mail.

Provider portal: https://providerportal.caresource.com/ky
Fax: 1-855-262-9793
Mail: Humana – CareSource
Attn: Provider Appeals — Clinical
P.O. Box 823
Dayton, OH 45401

Quality Improvement Program Goals

Humana – CareSource's overarching goal is to continually assess and analyze the quality of care and service offered to its members, utilizing objective and systematic monitoring and evaluation and to implement programs to improve outcomes.

This process is dynamic in order to continuously respond to the needs of our members to the highest degree possible. These activities are embedded in Humana – CareSource's strategic business plan to ensure optimal coordination of activities within the company and to assure that our entire organization is working toward the common goal of continuous improvement. The quality improvement program is overseen and facilitated by the chief medical officer. On an annual basis, Humana – CareSource makes information available about its quality improvement program and results to providers on its website. On an ongoing basis, Humana – CareSource gathers and uses provider performance data to improve quality of services.

Scope of Quality Program/Global Objectives

The Humana – CareSource quality program encompasses a spectrum of performance categories including, but not limited to, the following with the objective to continuously improve in all areas:

- Clinical quality and effectiveness of care, including behavioral health and member safety
- Quality of service and key performance metrics
- Business process improvement
- Data integrity and management
- Provider and member service and satisfaction
- Service utilization/medical cost ratio
- Over/underutilization of services
- Delegated oversight
- Accreditation
- Clinical performance metrics

Quality improvement program activities include monitoring clinical measures and outcomes, appropriateness of care, Healthcare Effectiveness Data and Information Set (HEDIS) measures, barrier analysis and strategic interventions. The quality assessment committee is delegated by the board to monitor and evaluate the quality assessment and performance improvement program. This committee is also responsible for identifying, planning and implementing interventions to promote continuous quality improvement.

Access Standards
Humana – CareSource has a comprehensive quality improvement program to help ensure our members receive the best possible health care services. The quality improvement program includes evaluation of the availability, accessibility and acceptability of services rendered to members by participating health care providers.

Please keep in mind the following access standards for differing levels of care. Participating providers are expected to have procedures in place to see members within these time frames and to offer office hours to their Humana – CareSource patients that are at least the equivalent of those offered to any other patient. Thank you for adhering to these standards.

Primary Care Providers

Patients with:	Should be seen:
Emergency needs	Immediately upon presentation; 24 hours a day, seven days a week
Persistent symptoms	Not to exceed 48 hours from date of a member's request
Routine care needs	Not to exceed 30 days from date of a member's request

Non-PCP Specialists

Patients with:	Should be seen:
Emergency needs	Immediately upon presentation
Persistent symptoms*	Not to exceed 48 hours
Routine care needs	Not to exceed 30 days (stable condition)

(this language moved to below)

Behavioral Health

Patients with:	Should be seen:
Emergency care	Must be provided within 24 hours, crisis stabilization
Urgent care	Within 48 hours
Routine office visit	Shall not exceed 21 days
Post discharge from an acute psychiatric hospital	May not exceed 14 days

Other referrals may not exceed 60 days

**A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a provider is unable to see the member within the appropriate time frame Humana – CareSource will facilitate an appointment with a participating provider or a nonparticipating provider, if necessary.*

For the best interest of our members and to promote their positive health care outcomes, Humana – CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between medical care providers and behavioral health care providers.

General vision, lab and X-ray wait times shall not exceed 30 days for regular appointments and 48 hours for urgent care.

Dental wait time shall not exceed three weeks for regular appointments and 48 hours for urgent care.

External Quality Reviews
Through our contract with the commonwealth of Kentucky, we are required to participate in periodic medical record reviews. The commonwealth retains an external quality review organization (EQRO) to conduct medical record reviews for Humana – CareSource members. You may periodically receive requests for medical record copies from an EQRO or from Humana - CareSource fora review. Your contract with Humana – CareSource requires that you furnish member medical records to us for this purpose. EQRO reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As in the past, we plan to continue sharing the results of these studies and working in partnership to achieve the best health care possible for our members.

Tips for Complete Medical Record Documentation
Humana – CareSource realizes that supplying medical records for review requires your staff's valuable time and we appreciate your cooperation with our requests and associated timelines. We offer the following suggestions to ensure complete and accurate documentation of member services:

- Use legible handwriting for paper medical records
- Consider dictated notes which can improve comprehension of medical records while reducing the chance of misinterpretation
- Include the patient's name on front and back of every page of the medical record
- Initial and date lab results in the medical record to indicate that they have been reviewed by a physician
- Record all patient visit dates and sign all chart entries
- Consider using preprinted forms to document all aspects of comprehensive services such as EPSDT exams

We appreciate your attention to detail in chart documentation.

Provider Performance and Profiling
As a function of medical management oversight responsibilities, Humana – CareSource monitors over- and underutilization of medical services. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services, Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures and pharmacy utilization. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is under development.

If a provider is found to be performing below minimum care standards for participation with Humana – CareSource, this information is shared with the provider so he or she can make positive changes in practice patterns. We are committed to working with the provider to develop an action plan for improvement for those who do not meet the standards. Further action may include onsite assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with physicians, reporting deficiencies to appropriate authorities or termination of participation with Humana – CareSource.

Preventive Guidelines and Clinical Practice Guidelines
These clinical treatment protocols are systematically developed statements that help providers and members make decisions regarding appropriate health care for specific clinical circumstances or for specific age ranges. The use of these guidelines allows Humana – CareSource to measure the impact of the guidelines on outcomes of care. Treatment protocols, based on national standards, are developed with the input of local health care providers who are part of the Humana – CareSource quality improvement committees.

Preventive health guidelines and clinical practice guidelines are distributed to:
a. All new and existing providers via provider manual updates, provider newsletters, our provider website, care management and/or provider relations representatives.
b. Updates to providers will be communicated in writing by mail, fax or email.

Preventive guidelines and clinical practice guidelines also are available at CareSource.com/ky.

NOTE: Information is available to providers and members upon request if not available on the website.

Quality Assessment and Performance Improvement Program (QAPI)
Humana – CareSource has a QAPI program that includes but is not limited to the following elements:
- Performance improvement projects
- Over and underutilization measures
- Annual analysis of plan demographics including clinical, geographical and cultural to identify high risk populations, areas of network need, member education opportunities and performance improvement opportunities
- Assessment of access and availability of network providers including after-hours availability of primary care physicians
- Assessment of quality and appropriateness of care furnished to children with special health care needs
- Continuity and coordination of care
- Healthcare Effectiveness Data and Information Set HEDIS measurement
- Consumer Assessment of Health Plan Survey (CAHPS)
- Annual measurement of effectiveness review of the QAPI

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 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 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

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.

Humana – CareSource partners with HealthHelp to provide consultation of High 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.

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 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

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.

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