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 is available 8 a.m. to 6 p.m. Eastern time for 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 is identified by name, title and organization name when initiating or returning calls regarding UM issues
- Staff is available to accept collect calls regarding UM issues
- Staff is 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 health partners. 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 health partner)
- 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 health partner)
- 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 health partners for:

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

Medicaid Referral Procedures

A referral may be 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.

Please place 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. Requests can be faxed to 1-888-246-7043 using the Prior Authorization Request Form located at **CareSource.com/providers/kentucky/medicaid/provider-materials/forms/**. 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 Health Partner 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. Referring health partners must be enrolled in Medicaid.

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

Referrals for second opinions — A second opinion is not required for surgery or other medical services. However, health care partners 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 health partner for a second opinion:

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a nonparticipating health partner. The health partner must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.

- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner 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 **CareSource.com/providers/kentucky/providerportal/**

Email: **kymedicalmanagement@caresource.com**

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
- Health partner 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 health partner, 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. Health partners 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 health partner. Humana – CareSource will notify you of prior authorization determinations by a letter mailed to the health partner address on file.

For standard prior authorization decisions, Humana – CareSource provides notice to the health partner 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.

Administrative denials may be rendered when applicable authorization procedures are not followed. Members cannot be billed for services that are administratively denied due to a health partner not following the requirements listed in this manual.

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, nonemergent procedures for consultation:

- Magnetic resonance imaging (MRI)/magnetic resonance angiogram (MRA)
- Computerized tomography (CT)/computed tomography angiography (CTA) scans
- PET scans

Ordering physicians are required to be enrolled in Medicaid.

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 nonstress 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 uses Kentucky forms for authorization of abortion, sterilization and hysterectomy. These forms can be accessed directly from:

- the Kentucky Medical Management Information System (KYMMIS) website under "Provider Relations Forms" at http://www.kymmis.com/kymmis/Provider%20Relations/ProviderRelationsForms.aspx
- on Humana – CareSource's secured website at **CareSource.com/KY**.

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

Please remember the following 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.